MEDICARE PROVIDER SERVICE NETWORKS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

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WEDNESDAY, MARCH 19, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:15 p.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hastert, Klug, Deal, Bilbray, Ganske, Norwood, Coburn, Cubin, Brown, Waxman, Pallone, Eshoo, Stupak, DeGette, and Furse.

Also present: Representative Gillmor.

Staff present: Howard Cohen, majority counsel; Eric Berger, majority professional staff; and Kay Holcombe, minority counsel.

Mr. BILIRAKIS. Will the hearing come to order.

The chairman and the ranking member will have 5 minutes for their opening statements. I would like to limit the others to maybe 3 minutes, so, hopefully, we can get rolling and go on to our members.

Today I am pleased to convene this hearing on the important issue of establishing provider-sponsored networks, which we fondly call PSNs, in the Medicare program. Although all sides agree that PSNs should be able to participate as Medicare risk contractors, there is a fundamental disagreement on how they should be regulated, particularly in regard to solvency standards. We will not solve that problem today; however, I am hopeful that this hearing will provide the subcommittee with a spirited but intelligent discussion of the issues.

I would also like to acknowledge several of our witnesses. On the first panel we have two of our fellow members who have been very much involved in the health care debate: Jim Greenwood and Charlie Stenholm.

We also have testifying one of our distinguished former colleagues, Bill Gradison, who was a leader, a scholar, and a gentleman during all the important health debates which took place during his tenure as ranking member of the Ways and Means Subcommittee on Health. And Bill was a member that both sides of the aisle looked to for leadership and advice.

For the benefit of the many new members of this subcommittee, I would like to briefly describe the rationale for the provider service network provisions of the 1995 conference report on the Balanced Budget Act. In 1995, Republicans believed that it was imperative

to provide Medicare beneficiaries with new, integrated health care plan choices.

We believed that our elderly population deserved to have the same options that are available in today's innovative health care marketplace for the nonelderly. We were confident that the elderly could then choose the health plan that best suits their needs. Therefore, we developed a new Medicare choice system. The most important feature of that new system was provider-sponsored networks.

PSNs are health care entities designed and operated by physicians and hospitals, by providers, if you will. Their goal is to deliver health care in a more efficient manner by cutting out the administrative costs associated with insurance companies and managed care companies.

We also believed that PSNs would provide rural areas the opportunity to establish integrated managed care networks in Medicare. This goal went hand-in-hand with our efforts to dramatically increase the AAPCC for these counties. With increased reimbursements and new models for managed care, we were confident that Medicare beneficiaries throughout the entire country would now benefit from new choices.

In an attempt to jump-start PSNs and be responsive to provider complaints that they were not receiving a fair hearing from State insurance departments, we established a complicated regulatory scheme which was a compromise among providers and insurers. Like all compromises, it made all sides unhappy.

With regard to solvency, the Balanced Budget Act would have instituted Federal solvency standards which would have been developed by the Secretary. State solvency standards would have been preempted by the Federal standards, which would have been developed by an expedited, negotiated rulemaking process. Other State HMO laws would still apply to these PSNs, but a PSN could obtain a waiver for the State requirements, under conditions in which the State was creating unnecessary roadblocks for licensure.

Since 1995, the National Association of Insurance Commissioners, the American Academy of Actuaries, and insurers and providers have all looked very closely at the regulatory issues involving PSNs. As our fourth panel will make quite evident, there is a fundamental disagreement on how they should be regulated and by whom, particularly regarding solvency.

Let me refer to this chart to my right to show the criteria that I plan to use in making up my mind. I believe that the critical issue is the protection of the Medicare beneficiary. When any health insurance organization assumes insurance risk by accepting a Medicare premium payment based on the AAPCC, we in Congress want to make sure that the beneficiary is receiving all of the health care services that they are entitled to.

We do not want the health insurance organization to transfer the insurance risk to the elderly beneficiary because the plan is insolvent or because the plan is so significantly undercapitalized that full benefits are not being provided, or because physicians and hospitals have been forced to work on greatly reduced incomes, because so-called "sweat equity" is a PSN's major asset.

PSNs in the Medicare marketplace must meet rigorous solvency standards that ensure that our Nation's elderly population receives the Medicare benefits which they are entitled to. We cannot afford to let our Nation's senior population bear the risk of insolvency or substandard care as we proceed to develop models for PSNs.

Thank you. I now yield to the gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Thank you for holding today's hearing on provider-sponsored organizations. I would also like to thank Congressman Greenwood and Congressman Stenholm for appearing before us today to testify on H.R. 475, which seeks to help providers establish PSOs to offer medical care directly to Medicare beneficiaries.

Last, I would like to extend a special welcome to my friend Dave Randall, who is deputy director of the Ohio Department of Insurance, and Glenn Pomeroy, the North Dakota Insurance Commissioner, and brother of our colleague, Earl Pomeroy. They will both be testifying on behalf of the National Association of Insurance Commissioners.

I think everyone here today agrees that offering Medicare beneficiaries more choice in providers is a good idea. However, the issues we will address during today's hearing are obviously a bit more complicated than simply allowing doctors, hospitals, and other health professionals to compete with managed care companies for the delivery of Medicare services.

While I appreciate the arguments being advanced by providers that they require Federal preemption of State solvency and quality standards due to the unique nature of PSOs, as compared to traditional HMOs, in order to level the competitive playing field with HMOs, I also have some concerns that the proposals being considered by the subcommittee today may have the unintended effect of reducing the quality to which Medicare beneficiaries are accustomed.

While physicians are good at treating patients, they may not necessarily be equipped to handle the insurance risk which comes with managing a PSO. I am concerned that waiving State solvency requirements without adequate Federal oversight could put Medicare beneficiaries enrolled in these plans at some risk.

Without the 50/50 rule, which serves as a proxy quality requirement by ensuring that Medicare plans also serve 50 percent private enrollees, we cannot be sure that Medicare beneficiaries will continue to have access to high quality medical care.

However, as HMOs have grown to dominate 75 percent of the private health insurance market and are enrolling Medicare beneficiaries at a skyrocketing rate, reaching somewhere around 13 percent nationally, I felt strongly we must offer beneficiaries an alternative to traditional managed care.

Furthermore, understanding the power that HMOs currently wield over providers and Medicare beneficiaries, in the form of gag clauses and restrictions on a patient's access to specialty care, I find it interesting that HMOs are arguing that these Federal preemptions would put them at a significant competitive disadvantage to PSOs.

I hope that today's testimony will further enlighten us on how best to encourage alternatives to traditional Medicare HMOs, while

ensuring that beneficiaries continue to have access to affordable and high-quality medical care.

Mr. Chairman, I ask unanimous consent, also, that all members be allowed to enter their opening statements in the record.

Mr. BILIRAKIS. Without objection.

The continuing opening statements will be limited to a strict 3 minutes in the interest of time.

Dr. Ganske, I believe you were the first one in the room.

Mr. GANSKE. Thank you, Mr. Chairman.

I am very glad that we are holding a hearing on the issue of expanding Medicare to give seniors more choices. The 104th Congress passed a bill that would have allowed medical savings accounts and provider-sponsored organizations. I continue to believe that we should give seniors the option of enrolling in a medical savings account, as well.

I think the subject of today's hearing is critically important. The idea of allowing health care professionals to band together with hospitals to compete with HMOs is intriguing. These networks hold the great promise of increasing competition and holding down health care costs.

Perhaps equally important is the promise that PSOs hold for rural America, where managed care is largely absent. The development of networks owned and operated by health care professionals will bring more options to seniors in areas that have seen little HMO penetration.

It seems clear to me that organizations of health care professionals joined by hospitals are not the same as traditional insurance plans. Between their buildings and their sweat equity, they bring to the table the ability to deliver health care not possessed by most insurers.

So I look forward today to testimony on the appropriate level of solvency needed to ensure that PSOs will be able to meet the ongoing health needs of their enrollees. I think it's also important to note that we have already held hearings on the AAPCC issue. Getting a correct and a fair funding formula is important for PSOs, as well as HMOs and other types of choices that we will be looking at, to operate in rural and other under-served areas.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman.

I just want to say, obviously, this is a complicated issue. I hope our witnesses will help us develop a better understanding of PSOs. Specifically, I am hoping that we can unearth some details on the issues of solvency and the quality of care.

Certainly, the concepts behind PSOs are ones that deserve to be examined. Their goal, of course, is to compete with HMOs to provide beneficiaries with high-quality care. Preserving access and choice for beneficiaries and containing health care costs are also stated objectives.

I understand the interest physicians have in seeing PSOs become viable organizations certified to compete for Medicare contracts. Working within a PSO would likely allow physicians greater autonomy than that granted to physicians working in HMOs. They

would, moreover, provide for the elimination of the middle man, thereby allowing beneficiaries to deal directly with medical professionals, instead of having to first go through an insurance company.

I want to say, in a very sincere sense, that I think that PSOs are a very good idea, and I like the idea of having physicians and providers involved in this way, but of course we have to be concerned about the structure. I know the argument is that, because they are not as large as HMOs and do not have as much liquid capital, they should come under different regulatory guidelines. Of course, this is the most important issue at hand today.

I think we have to address the issue of solvency standards, specifically if PSOs are to be certified to enter into Medicare contracts with the Federal Government. Congress must ensure that adequate solvency standards exist to protect beneficiaries and the Federal Government, should a PSO become insolvent.

I welcome Congressman Greenwood's and Congressman Stenholm's bill here, which I understand proposes to set Federal standards which, after 4 years, States could adopt to regulate PSO activities.

Mr. Chairman, let me just say that greater competition in managed care would certainly be a welcome development, and PSOs have the potential to bring such competition about. I hope today's hearing will help us develop a better understanding of the merits of PSOs, and I think it's very important that we do have this hearing.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Deal for an opening statement. No opening statement.

Ms. Eshoo for an opening statement.

Ms. ESHOO. Thank you, Mr. Chairman, for holding this hearing on what was already stated as a complex issue, but nonetheless a very important one to so many people in our country.

As the percentage of enrollment in managed care, in my State of California, reaches an all-time high of at least 30 percent, maybe even a little greater, issues surrounding managed care, such as the growth of PSNs, are of obvious interest to both myself and my constituents. I am encouraged by what health care providers are designing relative to innovate strategies to provide high-quality, cost-effective care to diverse populations, including Medicare beneficiaries.

PSNs, through their provider-controlled and operated health care delivery systems, I think are one of the more intriguing and effective methods for providing care, because treatment decisions are made by those who are directly affected by the outcome of the decisions, both the patients and their doctors.

So it seems to me, on the face of it, that PSNs have some inherent advantages over traditional HMOs. I'm not knocking HMOs off their blocks, but this is a very attractive option for people. There is, in theory, less bureaucracy, therefore greater patient-doctor contact. What I think we need to examine here today is, does theory equal reality?

I hope that those who are testifying will help us out with that. I very much look forward to hearing from my colleagues. For the audience that is here today, it isn't very often that colleagues come

before a committee or subcommittee to offer testimony. So I look forward to hearing what you want to say to us and advocate today, especially on specific Federal standards that you are advocating and why these standards are best achieved at the Federal level.

Thank you, Mr. Chairman. I don't have any time to yield back, but I will pull up the microphone. Thank you.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

Thank you for holding this hearing. I would just like to say that I think that we all agree that competition is going to be the key to the future of maintaining a high quality of health care capabilities while controlling costs. I think PSOs and related organizations are an essential part of that system that will create enough competition to keep everyone honest.

I think everybody wants a level playing field here. Some want their playing field to be a little more level than the other guy, and I think that's a legitimate advocacy role, but one thing that we have to do is try to figure out how to balance it out.

Mr. Chairman, my concern is that California has led the rest of the Nation in a lot of progressive approaches, be it health care or environment. The biggest concern we have is the Federal Government coming in, preempting us, and undermining our achievements of the past and denying them to the future.

I would just ask that we be very careful, as we encourage this option to expand competition, that we make sure that we do not punish those States and those areas that have been the leaders.

Once again, Mr. Chairman, I thank you for holding this meeting. I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Thank you for holding this hearing today. I notice we have an excellent group of witnesses to testify, and I look forward to hearing from them. I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

I appreciate the importance of this hearing today, and I especially thank Mr. Greenwood and Mr. Stenholm for introducing H.R. 475, of which I am pleased to be a cosponsor.

Mr. Chairman, with your permission, I will submit the rest of my opening statement for the record and yield back my time.

[The prepared statement of Hon. Charlie Norwood follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Chairman, thank you for holding this hearing today. I want to also take this opportunity to thank Mr. Greenwood and Mr. Stenholm for introducing H.R. 475, of which I am a proud cosponsor.

Mr. Chairman, most of us on this committee bear the scars of a protracted attack in the 104th Congress against Republicans fighting to preserve Medicare for future generations. I certainly know good people who are no longer on this Committee because political opportunism won out over good public policy. I certainly hope we can avoid such an event again this Congress.

One of the proposals agreed upon by both Congress and the Administration is expanding the use of provider sponsored organizations for delivering Medicare services to senior citizens. Both the President's budget proposal and the Balanced Budget Act included the use of PSOs. I believe this is a strong step in the right direction for expanding choices for Medicare beneficiaries.

I also worked to help the Federal Trade Commission see the light on its consideration of physician sponsored networks. I worked in my former life to help my colleagues establish PSNs, only to be blocked by arcane federal guidelines that didn't take into consideration the unique nature of a health care delivery network established and operated by physicians and hospitals. I am glad to know that the FTC will allow providers to offer delivery systems to help enhance competition in the health care market. I certainly hope that the same thing will occur for Medicare.

I believe there is also a compelling argument that choices for Medicare enrollees in rural areas will be well served by Medicare PSOs. Because there is frequently less penetration into rural areas by managed care than in urban areas, many people in rural communities, like those in my district, would be directly helped by PSOs and their entry into the delivery of Medicare services.

I am however concerned about the efforts of opponents of this enhanced competition to derail PSOs. When a health care network is established with the end goal of maximizing profits, there is a need for strong protections for patients. When a health care network is established to empower doctors and hospitals who feel their medical decision making ability is being subverted to the profit motive, providers will offer a different product. In my opinion, patient protections are built into networks offered by health care providers.

Despite statements to the contrary, delivery of health care from a network established by a physician and hospital is different than health care services offered by a network established by an insurance company. Providers of health care are sworn to protect the health of patients first. Insurance companies take no such oath. That is the difference between insurance-established networks and provider-established networks.

Mr. Chairman, I have no doubt that this hearing will include a spirited debate on these issues. I again want to thank you, as well as the witnesses here today, for discussing these important issues. I look forward to this discussion today.

Mr. BILIRAKIS. Mr. Stupak.

Mr. STUPAK. Mr. Chairman, I will be real brief. I will submit my statement for the record.

I look forward to the testimony and want to see how PSOs will help out in rural areas. I believe, for one, that PSOs that are run by doctors who live in the communities in which they practice can be a great advantage to rural areas, and I look forward to the testimony today.

[The prepared statement of Hon. Bart Stupak follows:]

PREPARED STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding these important hearings on Provider Sponsored Organizations. I believe this debate is crucial to the future of Medicare in rural areas.

While I am concerned about some of the allegations about the managed care industry that have recently surfaced in the news media, I have no doubt that managed care is, and will continue to be, a component of America's health care delivery network.

When managed care is run properly, it can be an effective way to provide quality and efficient health care treatment. Well run managed care plans emphasize preventive treatment, so members of the plan stay healthy. While managed care may not work for all seniors, all seniors should have the choice of whether or not to participate in a managed care plan. Unfortunately, senior citizens in rural areas have been denied that choice.

Provider Sponsored Organizations are one way to bring Managed Care to rural areas. Unlike HMOs, PSO's are not run by financial actuaries or bean counters, they are run by Doctors that live in the communities they practice in. In the HMO market, beneficiaries have higher satisfaction rates when the plans are locally operated. Unlike a large HMO, where a person in California will deny a procedure to

someone in North Carolina, local HMOs are dealing with their neighbors and relatives.

PSOs are even closer to the patients than HMOs. In a PSO your family doctor makes the decisions about what types of procedures are appropriate. I know for a fact that I would rather have my treatment decisions in the hands of a doctor I know and trust, than in the hands of an HMO employee on the other side of the Continent.

PSO's can be a vital piece of our health care delivery network. While the United States has the best health care in the world, it doesn't mean much if we don't have access to it. I agree that PSOs should meet solvency and quality standards that are protective of their patients. While I believe PSOs have different characteristics than HMOs that needs to be taken into account when they are regulated, I do not believe these standards should put the beneficiaries at risk and I will continue to work to ensure the solvency and quality assurance standards are sufficient to protect beneficiaries without creating unnecessary roadblocks for PSOs.

Mr. Chairman, I look forward to this hearing and to the discussion about PSOs. I commend Mr. Greenwood and Mr. Stenholm for their bill and look forward to working with them.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Hastert.

Mr. HASTERT. I thank the Chairman.

I would like to ask to put my written opening statement in the record. I just want to take a few words and say, first of all, congratulations for doing this. This is something that we have been working on for a couple of years.

Mr. Greenwood and Mr. Stenholm, I certainly congratulate you on bringing this issue forward.

When we were working on Medicare about 1½ years ago, this is something that came up. It was proposed that it may be something that could provide good services for people; it could provide a cost saving over and above the services that were provided to people.

We had to work some problems out: the solvency standards, the problems of antitrust. As a matter of fact, we had to change antitrust law to see that these things would even be workable. Actually, the attorney general and her department have worked toward this in opening some of those solvency or antitrust rules so that these things actually have been able to come together and start to work.

In rural areas, where AAPCC almost prohibits the ability for HMOs to come together and be effective, this is an answer that small communities with several doctors and a hospital can get together and work together. It's not a panacea. It doesn't have all the answers, but it's something that has some promise of workability.

I think one of the things that we have to do in this Congress is to explore all those avenues. How can we move forward, do a better job for people, and bring a fairness across the board so that all people can get good health care? Many different types of delivery systems have to be in place to do that.

So, Mr. Chairman, I congratulate you for holding this hearing today, and certainly to Mr. Greenwood and Mr. Stenholm for bringing it forward.

I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Furse for a 3-minute opening statement.

Ms. FURSE. I would just like to submit mine for the record, please.

Mr. BILIRAKIS. Without objection.

Ms. Degette.

Ms. DEGETTE. I will submit my opening statement for the record, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

I appreciate the brevity up here. We don't see that much of it usually. I think Mr. Waxman sort of started us off.

All right. Our first panel consists of the Hon. Jim Greenwood, from Pennsylvania, and the Hon. Charles Stenholm, from Texas. Five minutes for each.

Charles, we'll start off with you.

STATEMENTS OF HON. CHARLES W. STENHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND HON. JAMES C. GREENWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. STENHOLM. Thank you, Mr. Chairman. I, too, commend you for holding this hearing.

I have a rather lengthy statement, and explanations and other supporting documents, that we would like to submit for the record. We will attempt, within my 5 minutes, to talk about why we are here.

As one who has never served on a health subcommittee, I come before you today with a proper sense of humility. Through the years, I have gained some experience in helping to construct health reform suggestions, one of which happened to be called "Rowland-Bilirakis."

There were variations in the several proposals I have supported, but there also were some common themes and goals. It is those goals of cost containment, access to care, and quality assurance which brought me to cosponsoring the Greenwood-Stenholm Bill this year.

My first goal has been to try to get a handle on burgeoning Medicare costs, and managed care has played a prominent role in that equation. I find it interesting that much of which we found unpalatable as legislative policy reform a few years ago has developed on its own within the marketplace, and cost savings has been the result. But while the market's version of managed care, unaided by government safeguards, has performed commendably on the cost side, it has shown some serious deficiencies when measured by a few other standards.

First, is spotty market penetration. I represent a very rural district where, except for the Defense Department's Tricare Program, managed care is virtually nonexistent. I understand that our government's reimbursement policies make market penetration into my district unreasonable, from a business perspective. That's why I strongly urge changes in the AAPCC to coincide with PSO reform.

My point today, though, is that PSOs are a significant piece of the puzzle to both cost containment and the access questions. They provide cost containment in the usual managed care manner, but they are more responsive to access concerns, because PSOs rely on providers already serving in unpenetrated areas.

I have heard the argument from existing managed care companies that, if they can't afford to serve rural areas, unsophisticated, rural providers forming new PSOs will never be up to the economic

challenges. That argument sounds an awful like the attitude my parents heard in the 1930's when large electric utility companies wrote off electricity for rural America. Interestingly enough, rural electric coops, run by local residents and supported by Federal policy, proved these large companies wrong.

I'm going to put my faith in rural ingenuity and cooperation, just like my parents did. I believe, if paired with helpful government policies, PSOs will play a meaningful role in expanding access to economical health care in rural and underserved areas.

Another persistent goal for me has been concern about quality of care for Medicare beneficiaries. Here again, I'm not sure that the unguided market has done all that rational policy could and should have. In no circumstance would we support PSO reforms which would bring about a lessening of consumer protection. In fact, we argue strongly that beneficiaries are protected to a greater degree by our legislation.

To begin with, providers who have a direct relationship with their patients will be the decisionmakers about plan coverage. I don't intend to engage in insurance company bashing, which is currently fashionable. In fact, I would point out that insurance companies must play a meaningful role in the PSO concept. But I do have a bias that looks kindly on face-to-face, community-based solutions.

Under our PSO concept, clinical decisions will be in the hands of local practicing physicians, and communities will have the chance to oversee decisions which take into account the long-term health and economic needs of the community at large.

Numerous Medicare consumer protection standards, which currently are applied to HMOs, would apply to PSOs, as well. But, in other cases such as utilization review and physician participation, PSOs would have to meet even further standards. The bottom line, overall, should be a plus for consumers.

Many important technical details need to be worked out, even among people who all support the concept of PSOs. How the specific lines are drawn is of substantial and economic importance to the people filling this room. Jim and I earnestly request that those who oppose portions or all of this bill offer concrete recommendations on how it might be improved while preserving the stated goal.

We have attempted to find a reasonable middle ground on a number of tough issues. Take solvency standards, for example. I can assure you that I have no interest in creating the health care equivalent of the savings and loan crisis we experienced in the 1980's. I want those organizations which claim they can provide quality, comprehensive care to be forced to show that they are up to the task, not just for a quick buck, but for the long haul. That's why this bill lays out some standards which some of your witnesses today will tell you are too stringent.

Mr. BILIRAKIS. Please summarize, Charles.

Mr. STENHOLM. I thank you, Mr. Chairman.

I want to close with a final comment, not on the substance, but rather on the politics. I hope we have all learned something by our inability to find some constructive middle ground, and that's why we believe that the legislation before us today has removed some of the many rough edges and put it together in something that will,

in fact, do that which you and I know the rest of your committee would like to see done.

[The prepared statement of Hon. Charles Stenholm follows:]

PREPARED STATEMENT OF HON. CHARLES W. STENHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, I commend you and your subcommittee for holding this hearing today on the subject of provider sponsored organizations, otherwise recognized in Washington's alphabet soup as PSOs. I also want to commend my colleague, Jim Greenwood, for his leadership on H.R. 475, the PSO bill on which I am proud to be lead cosponsor.

Sitting here with the subcommittee which drafted PSO language in the last Congress, associations which know every technical—not to mention economic—jot and tittle of this market device, and providers who actually are operating this form of managed care, I assure you that this farmer comes before you with a proper sense of humility.

Through the years I have gained some experience in helping to construct health reform suggestions: one called Cooper, one called Cooper-Grandy, one called Rowland-Bilirakis, and so on. While there were variations in those proposals, there also were some common themes and goals, and it is those same goals of cost containment, access to care, and quality assurance which brought me to cosponsoring the Greenwood-Stenholm bill this year.

Through the years, my first goal has been to try to get a handle on burgeoning Medicare costs. For most of this decade, managed care has played a prominent role in that equation. I find it interesting that much of which we found unpalatable as legislated policy reform a few years ago has developed on its own within the marketplace and, indeed, cost saving has been the result.

I must immediately add critical caveats to the point just made, however. For while the market's version of managed care, unaided by government safeguards, has performed commendably on the cost side, it has shown some serious deficiencies when measured by a few other standards.

The first deficiency is spotty market penetration. The 17th District of Texas which I am honored to represent, has a land mass about the size of South Carolina; in other words, I represent a very rural district. In my biggest city, Abilene, with a population of 110,000, there would be a 1% managed care penetration were it not for the Defense Department's TriCare program. Needless to say, managed care in most of my 30 rural counties is entirely non-existent. I understand that our government's reimbursement policies make market penetration into my District totally unreasonable from a business perspective, but that alphabet-soup-issue, the AAPCC, is one on which I will lobby this and other committees another day.

For purposes of this hearing, my point is that PSOs are a significant piece of the puzzle to both the cost containment and the access questions. They provide cost containment in the usual managed care manner, but they are more responsive to access because PSOs rely on providers already serving in unpenetrated areas.

I have heard the argument from existing managed care companies that if they can't afford to spread into unserved areas now, these new PSOs will find it no more economically viable in the future. That argument sounds an awful lot like the one my parents heard in the 1930s when large electric utility companies told them they couldn't afford to provide electricity to rural America. Interestingly enough, rural electric co-ops, supported by federal policy, proved those large companies wrong, and I believe the same can happen with PSOs today.

Another of the persistent goals of any health reform effort I've associated with has been concern about quality of care issues for Medicare beneficiaries. Here agin, I'm not sure that the unguided market has done all that rational policy could and should have.

In no circumstance would we support PSO reforms which would bring about a lessening of consumer protections. In fact, we argue strongly that beneficiaries are protected to a greater degree by our legislation. To begin with, providers who have a direct relationship with their patients will be the decision-makers about plan coverage. I don't intend to engage in insurance company bashing which is currently fashionable, but I do have a bias that looks kindly on face-to-face, community-based solutions. Under our PSO concept, clinical decisions will be in the hands of local practicing physicians, and communities will have the chance to oversee decisions which take into account the long-tem health and economic needs of the community at large.

Numerous Medicare consumer protection standards which currently are applied to HMOs would apply to PSOs as well, but in other cases, such as utilization review and physician participation, PSOs would have to meet even further standards. In addition, the proxy for quality control, the so-called 50-/50 rule, would be waived only in cases where other higher quality standards are met. The bottom line overall should be a plus for consumers.

Now, I know that within the context of the general goals of cost containment, access, and quality assurance which I have outlined to this point, there are a lot of very important technical details to be worked out, and those details will be the essence of much of the testimony you hear today. Even among people who all support the concept of PSOs, how the specific lines are drawn are of substantive and economic importance to the people filling this room.

I'm not saying that the bill Jim and I put together is perfect and shouldn't have a comma changed. We earnestly request that those who oppose portions or all of this bill offer concrete recommendations on how it might be improved while preserving the stated goals. We have attempted to find a reasonable middle ground on a number of tough issues.

Take solvency standards, for example. Having lived through some dreadful votes in the 1980s when we picked up the pieces from a savings and loan debacle that never should have happened, I can assure you that I don't wish to create the health care equivalent. I want these organizations which claim they can provide quality, comprehensive care to be forced to show that they're up to the task, not just for a quick buck but for a long haul. That's why this bill lays out some standards which some of your witnesses today will tell you are too stringent.

Others will say the opposite, but I also reject their argument that only the current standards, only the businesses which currently are profiting from our present regulations, can safeguard the steadfastness of managed care operations. Our bill specifies explicit as well as general measures for fiscal soundness which reflect current HMO and insurance regulatory practices, modified to recognize the different operational characteristics of qualifies PSOs.

We know that there are many legitimate questions about the solution which Jim and I have developed, and so we request the opportunity to submit for the record several explanatory pieces about our legislation. These documents outline a summary of the bill, explain the solvency requirements included in the bill, describe differences from this bill and legislation considered in the 104th Congress, and respond to some of the most commonly asked questions about H.R. 475. We believe that this information will be helpful to anyone seriously studying our PSO alternative.

I want to close with a final comment not on the substance but rather the politics of our proposal. If any lesson should have been learned in recent years, first by the Democratic White House in 1993-1994 and then by the Republican Congress in 1995-1996, surely it is this: We represent a Country which longs for middle-ground, bipartisan, common sense answers to the very real challenges before us. Extremism on either pole and blind partisanship do no one, either politicians or constituents, any lasting good. Both by the bipartisan representation of this bill's cosponsors and the substantive middle-ground of its policies, we believe this is an approach Americans will endorse as they personally struggle with their own microcosm of health care cost, access, and quality issues. Both the President and Republicans endorsed the PSO concept in their budgets of the 104th Congress. This year, the so-called Blue Dog Coalition has already proposed a balanced budget which incorporates these very ideas. I urge this Committee to follow that lead and refine its PSO language in a bipartisan, middle-ground way which not only helps to meet the health care challenge but restores Americans' confidence in the process at the same time.

Thank you again, Mr. Chairman, for your courtesy in allowing my friend from Pennsylvania and I the time to speak on behalf of our PSO proposal.

SHORT SUMMARY, H.R. 475, THE MEDICARE PROVIDER-SPONSORED ORGANIZATION ACT OF 1997

The bill would amend Sec. 1876 of the Social Security Act. In addition to adding provider-sponsored organizations (PSOs) to the managed care options available to Medicare beneficiaries, the legislation would authorize the Secretary of Health and Human Services to enter into partial, as well as full, risk payment arrangements with PSOs and all other providers of managed care under Medicare. It would also address such issues as the coverage of emergency services by Medicare health plans and barriers to the formation of PSOs and to managed care.

There are several major features of the bill. They deal with definitions, standards, certification and enforcement, payment, emergency services coverage and barriers. Here are the high points of each.

DEFINITIONS

A provider-sponsored organization is a public or private provider, or group of affiliated providers, organized to deliver a spectrum of health care services under contract to purchasers.

Since not every PSO is ready to provide the full spectrum of Medicare services on a contracted (capitated) basis, the act defines PSOs that are "qualified" for Medicare direct contracting purposes. In addition to meeting most current HMO/CMP and new proposed PSO requirements, *qualified PSOs* must deliver a "substantial proportion" of Medicare services directly through affiliated providers. *Affiliated providers* are those under common control or ownership, or who share substantial financial risk.

The Act requires the Secretary of HHS to define what constitutes a *"substantial proportion"* of services. The bill suggests that significantly more than a majority of contracted services should be provided through affiliated providers, with most of remaining services covered by written agreements that protect consumers.

Standards

PSOs would fall under the same standards and contracting requirements as those that now apply to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)—risk contractors now able to provide managed care under Medicare—with only a limited number of revisions. These revisions are designed to eliminate barriers to PSOs while maintaining consumer protections and emphasizing quality assurance. Under the proposal, the current requirement that a plan's enrolled population include at least 50 percent commercial enrollees (the "50/50" rule) would be waived for any risk contractor that met new, enhanced quality requirements. In addition, PSOs would be subject to the following new requirements:

State Licensure. PSOs would not be required to obtain a state license to offer prepaid health services for at least four years. Federal law would preempt state licensure enforcement, but only for Medicare. After that, state licensure would be required if the state's requirements were sufficiently similar to the federal requirements.

Solvency. The bill builds on fiscal soundness and solvency standards that were developed by the National Association of Insurance Commissioners (NAIC). It slightly modifies provisions from the HMO Model Act to take into account how affiliation arrangements are structured within PSOs. The bill also recognizes a variety of alternative means, that many states already use, for demonstrating fiscal soundness. Finally, it ensures that the health delivery assets of a PSO are recognized in calculating net worth, as was provided in the NAIC's model HMO act (and related investment rules), but which has been unevenly recognized by states.

Quality. The enhanced quality requirements are designed to promote state-of-the-art continuous quality improvement and to ensure that consumers have useful quality information. PSOs would go further: those that currently rely on case-by-case utilization review—which consumers and doctors find too intrusive—would have to move toward evaluating patterns of care; they would guarantee physicians an integral role in setting medical policy and designing quality and medical management processes; and they would ensure fair treatment of physicians in the operation of networks.

Minimum Enrollment. The minimum enrollment levels would be changed from 5000 to 1500 (from 1500 to 500 PSOs serving rural areas).

Certification and Enforcement

The Secretary of HHS is required to publish interim standards for qualified PSOs within 180 days of enactment. Permanent rules would go into effect on January 1, 2002. A process for certifying PSOs that ensures approval or denial of applications within 90 days must also be established. The Secretary is required to consult a range of experts—the National Association of Insurance Commissioners, American Academy of Actuaries, state health departments, quality experts, associations representing provider-sponsored organizations, and Medicare beneficiaries—in developing the standards. HHS would involve state agencies in monitoring ongoing PSO performance and beneficiary access to services.

Payment

PSOs entering into Medicare full risk contracts would be paid on a capitated basis. Rates would be set in the same way as they are for HMOs and CMPs—currently, 95 percent of the Adjusted Average Per Capita Cost (AAPCC) for their area. The Secretary of HHS would also be allowed to enter into partial risk payment arrangements with any risk contractor. These arrangements, while providing the full

Medicare benefit package, would pay contractors a mix of capitated rates and costs, making PSOs more feasible in rural areas and ensuring that the Medicare program shares in savings from efficiencies.

Emergency Services Coverage

The bill reconciles requirements for coverage of emergency services with the requirements of the federal Emergency Medical Treatment and Active Labor Act (known as EMTALA) by requiring coverage of screening and stabilization services, and ensuring that any required precertification process for subsequent services be expedited.

Barriers

The Department of Justice and the Federal Trade Commission would be required to publish explicit guidelines on the application of antitrust laws to PSO activities and those guideline would be made binding on federal enforcement and be guidance to state enforcement of state antitrust laws.

The bill would preempt state anti-managed care laws that prohibit the use of several managed care techniques, but reserves the right of states to regulate or limit abusive arrangements or practices that act inappropriately to withhold, limit, or delay access to covered services.

Additional provisions authorize demonstration programs in at least 10 states to explore delivering a full continuum of care to persons eligible for both Medicare and Medicaid, and permit states to recognize PSOs as qualified coordinated care entities under Medicaid.

Explanation of Solvency Requirement in House (H.R. 475) Provider-Sponsored Organization Acts of 1997

This bill establishes the standards and requirements that would apply to qualified provider-sponsored organizations (PSOs) to ensure that adequate provision has been made against the risk of insolvency. The test is that a PSO be fiscally sound, as is currently required by Medicare for HMOs and CMPs. The bill goes on to specify explicit as well as general measures for fiscal soundness which reflect current HMO and insurance regulatory practices, modified to recognize the different operational characteristics of qualified PSOs.

How were the net worth and reserve requirements set?

The net worth and reserve requirements were drawn from the current model HMO act developed by the National Association of Insurance Commissioners (NAIC). They were slightly adjusted to take into account how affiliation arrangements are structured within PSOs.

Take, for example, one of the NAIC calculations for net worth that separates patient care expenditures that are and are not paid on a capitated or managed hospital payment basis. The NAIC terms carry an underlying presumption that the HMO is separate from the providers with which it contracts. In the case of a PSO, the affiliated providers *are* the PSO and a variety of methods are used to distribute revenue and risk within the affiliated group. To avoid unnecessarily restricting internal PSO arrangements with affiliated providers, the terms used in this calculation in the bill were revised to separate the cost of care provided by affiliated providers from those of non-affiliated providers.

In addition, the bill specifically states that in applying statutory accounting principles to determine net worth, admitted assets will include health care delivery assets. Such assets are fully recognized by NAIC's model HMO act and their guidelines for permitted HMO investments, but have not been codified into NAIC's statutory accounting principles (the more conservative accounting rules required throughout the insurance industry). Delivery assets have been unevenly recognized by the states for purposes of determining the net worth of HMOs (they are not recognized for commercial insurers). For example, some states recognize 30 percent of the value of HMO delivery assets, others recognize the value of HMO delivery assets only up to 30 percent of total assets, and still others employ other variations. This provision simply ensures that the current NAIC recognition of HMO delivery assets is maintained for PSOs.

The bill clarifies a major accounting difference between HMOs and health care provider organizations, which is the treatment of government receivables due for more than 90 days as an admitted asset. Recognition is also provided for amounts received by qualified PSOs under subordinated debt as contributions to surplus, which is currently permitted under most state HMO laws.

WHAT ARE "ALTERNATIVE MEANS?"

Historically, the focus of financial solvency requirements for insurers has been to ensure an adequate cushion against unexpected events. A company's net worth was one measure of its ability to deal with the unexpected. On a state-by-state basis, other general measures of fiscal soundness often have been recognized to demonstrate protection against the unexpected. In some instances, the credit worthiness of one party is substituted for another. For example, letters of credit and guarantees are longstanding practices in the insurance world. The use of actuarial certifications is also a longstanding practice through which compliance with various standards under different circumstances can be established. The "alternative means" approach recognizes that the legal structures and relationships, as well as the business strategies, will vary across companies.

The alternatives listed in the bill are not exclusive and they may be used in any combination. The standard remains the same, a PSO must be fiscally sound. The methods will vary for demonstrating compliance with the standard. The alternatives include items found in state statute or regulation or practices common within the insurance industry. Following below is a description of each.

- *Letters of Credit.* An arrangement with a bank or other qualified financial institution to honor the financial obligations of a party to whom the letter is issued. In the context of a PSO, a bank would stand by to provide cash advances in the event of a specified but unexpected event. This both promotes liquidity and provides an additional cushion against unexpected loss. Letters of credit are currently used extensively in the regulation of reinsurers.
- *Financial Guarantees.* A guarantee is the promise of one party to infuse additional capital to another in the event of insolvency or potential insolvency. The guarantee of an affiliate is the promise by a party that is related to the promisee; in the context of a PSO the affiliate would generally be a hospital or the parent company in a hospital system. Affiliate guarantees are explicitly included to allow the financial strength of another member of the health delivery system to stand behind the PSO. Many current state insurance and HMO solvency rules permit an insurer to rely on the guarantee of a regulated affiliate. These rules would not apply in the PSO context because the other parts of the system are not regulated by insurance departments. Permitting affiliate guarantees for PSOs creates a level playing field.
- *Reinsurance or stop loss insurance.* Reinsurance is a longstanding practice embedded in the insurance arena. It has the effect of a second insurer providing a separate cushion against the losses of the original insurer. Reinsurance and stop loss insurance serve similar purposes. (Technically reinsurance only occurs where one insurance company insures another insurance company.) The risk covered by the stop-loss policy is usually 1) the risk that claims for one covered person in a given time period will exceed a defined dollar threshold (e.g. $25,000), or 2) the risk that claim costs for a defined group in a given time period will exceed a formula-defined dollar threshold (e.g. 120% of expected claims), or 3) both. In the context of a PSO, its financial liability is capped at the dollar threshold at which the stop-loss coverage would apply.
- *Certification by an independent actuary.* Actuaries are presently required to evaluate a variety of the business practices of insurers and render opinions on the sufficiency of the arrangements (e.g. with respect to claims reserves and pricing). In the context of a PSO, the actuary could similarly render opinions that would validate the adequacy or sufficiency of its arrangements. The use of actuarial certifications has enabled compliance with standards to be evaluated across a variety of different circumstances.
- *Unrestricted fund balances.* The net assets of a not-for-profit organization minus any funds (generally donations) which may only be used for designated purposes. This is an amount highly analogous to the net worth concept applicable to insurance companies but reflects accounting practices and principles appropriate to not-for-profit organizations.
- *Diversity of lines of business and presence of non-risk related revenue.* The relative risk associated with different types of payment arrangements will affect the overall riskiness of the organization. The extent to which a PSO is involved in full risk, partial risk, or fee-for-service arrangements will affect the need for a buffer against the unexpected.

HOW DOES THE PROPOSED PSO STANDARD SPECIFICALLY COMPARE TO MEDICARE'S CURRENT HMO/CMP AND NAIC'S MODEL REQUIREMENTS?

The attached chart lays out a comparison of the three sets of requirements.

WHAT ABOUT NAIC'S NEW RISK-BASED CAPITAL APPROACH?

NAIC's risk-based capital proposal for health organizations uses a much more complex formula to calculate net worth requirements. Because it incorporates many more variables reflecting each organization's operations, it has potential as a flexible measure of fiscal soundness. But it is still under development and suffers from many problems: (1) the underlying data and assumptions used to develop the risk-based capital formula for health organizations did not include any significant representation of staff model HMOs or other delivery-based models and therefore inherently favors non-delivery-based organizations; (2) its suitability for all types of health organizations has not been established; (3) the impact of implementing it has not been tested; (4) issues about how it deals with health plans that produce their own services remain unresolved; and (5) PSO issues, such as how to reflect that only a portion of a PSO's revenue is full risk, remain unaddressed.

It would be inappropriate to apply risk-based capital first to those organizations for which it was least designed to apply.

Comparison of Medicare HMO/CMP, Model NAIC HMO, and House and Senate Proposed PSO Solvency Requirements

(Note: a ✓ indicates that requirements are the same.)

January 23, 1997

Medicare HMO/CMP Requirement	Model NAIC HMO Requirement	Proposed PSO Requirement
Organization has made adequate provision against the risk of insolvency.	**Protection against insolvency.** Demonstrated through means described below.	✓ as Medicare.
Organization is fiscally sound. Requirement met by a net worth test, sufficient cash flow and liquidity and net operating surplus. These general requirements are addressed in different, but more specific ways in the NAIC HMO Model Act and the PSO proposal.	Not overtly stated. (See specific requirements below.)	✓ Same standard as Medicare, but varies in how to demonstrate test is met. Fiscal soundness may be demonstrated either by meeting specified net worth and reserve requirements or through reliance on a combination of factors which may include net worth and reserves.
Net worth based on: • Positive net worth	Net worth based on initial $1.5m, and after that the greater of: • $1m; • 2 % of premiums; • 3 months claims for uncovered expenditures (services for which an enrollee might be liable) • sum of 8% patient care expenditures except those paid on capitated or managed hospital payment basis and 4% patient care expenditures that are paid on capitated or managed hospital payment basis.	✓ Modeled on NAIC Model HMO Act. Net worth not less than the greater of: • $1.5 million at application and $1 million thereafter; • the sum of 8 percent of the costs of care not provided directly by organization or affiliated providers, and 4 percent of estimated costs of services provided directly by the organization or its affiliated providers; or • 3 months of uncovered expenditures.
	Definition of permitted investments includes: land, building, and equipment used for care delivery. This definition calls for these assets to be treated as admitted assets for purposes of the application of statutory accounting principles to HMOs.	In applying statutory accounting principles to determine net worth, admitted assets shall include: land, building and equipment assets used for care, government receivables due for more than 90 days, and other assets the Secretary chooses. Secretary shall recognize, as a contribution to surplus, amounts received under subordinated debt. (Secretary has authority to alter requirements for partial risk arrangements.)

Medicare HMO/CMP Requirement	Model NAIC HMO Requirement	Proposed PSO Requirement
Organization is fiscally sound, (cont.)		
Sufficient cash flow and liquidity to meet obligations.	Not explicitly provided, but generally addressed through net worth, reserve requirements and permitted investments. Specific liquidity test included through uncovered expenditures insolvency deposit (see below).	Not explicitly provided, but generally addressed through net worth, reserve requirements and permitted investments.
Net operating surplus.	Not explicitly addressed.	May be a factor relied on to demonstrate fiscal soundness.
Not addressed.	Not addressed explicitly, but individual states have provided for some of these provisions.	The Secretary shall recognize other, more general means to demonstrate fiscal soundness beyond the specific net worth and claims reserve provisions, including: letters of credit from a bank, financial guarantees from financially strong parties, unrestricted fund balances, certification by an independent actuary, reinsurance and stop/loss, or other acceptable methods.
Not addressed.	Reserves for unpaid claims.	Adequate claims reserves, as certified by independent actuarial analysis.
Insolvency plan for protection of enrollees.	**✓ as Medicare.**	**✓ as Medicare.**
The MCO must provide for either: - "Hold harmless" contract provision precluding providers from seeking payment from beneficiaries if premiums are paid but HMO or CMP fails to pay providers; or - Insurance acceptable to HCFA; or - Reserves restricted for use only in event of insolvency.	Requires hold harmless contract provisions in provider contracts. An uncovered expenditures insolvency deposit if such expenditures exceed 10% of total health care expenditures.	✓ as Medicare.
"Continuation of benefit" contract provision requires plan to provide for continuation of benefits for duration of contract period for which payment has been made for enrollees in inpatient facilities until discharge.	✓as Medicare, except allows options for how to meet requirement, including: continuation of care contract provisions, insolvency reserves, and insurance to cover benefits after an insolvency.	✓ as Medicare.
Cash or securities deposit not required.	Requires deposits of cash or securities of $300,000	✓ as Medicare.

QUESTIONS AND ANSWERS ON H.R. 475, PROVIDER-SPONSORED ORGANIZATION ACTS OF 1997

Q: Why is this proposal necessary?

A: There are two reasons. First, Provider-Sponsored Organizations (PSOs) are the best way to let local caregivers make decisions on how to provide appropriate, community-based, high-quality care. Second, the Medicare program will need many new entrants into the coordinated care market to reach desired levels of budget savings. PSOs are a critical component of this strategy because: (1) providers are the ones with experience in caring for the elderly and disabled; (2) without insurance middlemen, more dollars will go directly to patient care; and (3) there are many communities, especially rural areas, where there are no Medicare managed care plans, but PSOs are already there.

Q: What is a provider-sponsored organization (PSO)?

A: PSOs are public or private entities that are a provider, or group of affiliated providers, organized to deliver a spectrum of health care services (including basic hospital and physicians' services) under contract to purchasers of such services.

Q: Would all PSOs be eligible to contract with Medicare?

A: No. PSOs qualified to contract would be those that meet federal certification standards (e.g., solvency, quality, etc.), meet Medicare risk contractor requirements (e.g., minimum enrollment, marketing, consumer protection, etc.), and who can directly deliver the substantial proportion of Medicare contracted services to Medicare enrollees through their own affiliated providers.

Q: What's the difference between an affiliated provider and the participating providers with whom HMOs contract?

A: Affiliated providers are those that share a significant common economic interest through common ownership or control, or substantial shared financial risk. Participating providers are simply those who sign contracts to deliver services to an HMO's enrollees. Affiliation relationships require greater integration of provider interests and activities, leading to better coordination of care among providers and to greater efficiency.

Q: How is a PSO different than a Managed Care Organization (MCO)?

A: PSOs differ from MCOs in three basic ways: *First,* the core business of an MCO is the sale of health care coverage, while the core business of a PSO is the delivery of health care. *Second,* MCOs are paid primarily on a full-risk premium basis, while PSOs deal with a multiplicity of payment mechanisms. *Third,* most MCOs are predominantly financial intermediaries, whereas PSOs are predominantly care delivery organizations. Staff model HMOs (a very small percentage of HMOs) are also care delivery organizations, but they operate predominantly on the full risk model.

Q: Why can't PSOs just become HMOs or CMPs if they want to provide managed care to Medicare beneficiaries?

A: The state HMO licensure process is often slow, especially when there is an increase in the number of organizations applying and state HMO requirements are often not well designed for integrated delivery systems, especially in those states dominated by large insurance-based HMOs. For example, the states unevenly recognize health care delivery assets in calculating HMO net worth, even though NAIC's model HMO act and investment rules do. Since PSOs deliver most of their services themselves, rather than paying claims, recognition of their delivery assets is critical.

Q: Won't preemption of state insurance licensure requirements create a costly and duplicative federal bureaucracy?

A: No. The bill provides for coordination of federal and state efforts. Federal standards and certification are needed initially to ensure consistent standards for PSOs. Even so, HHS would contract with states during the initial four-year period to monitor overall performance and beneficiary access to services taking advantage of the states' ability to provide more local oversight. After the first four years, state licensure would be required if the state's requirements were sufficiently similar to the federal requirements. Furthermore, any expansion in the number of managed care plans requires an expansion in regulatory capacity without regard to whether regulation is done at the state or federal level. The current lengthy HMO application process suggests that state HMO regulators do not currently have unused capacity available to regulate PSOs. Also, any increase in federal regulatory costs associated with PSO certification would be borne by user fees paid by the PSOs themselves, not the taxpayers.

Q: Won't federal certification instead of state licensure for PSOs mean different standards that create an unlevel playing field?

A: No. *First,* identical standards for different types of entities are what create an unlevel playing field—separate standards designed to achieve equivalent consumer protection that recognize each entity's structure and operating environment, are

what's needed. *Second,* given the variation in HMO licensure requirements across the states, Medicare beneficiaries would more likely have equal access to PSOs as an option if a common and appropriate level of requirements were applied. *Finally,* states would be allowed to take over the regulation of PSOs after four years if their requirements are sufficiently similar to the federal requirements. That incentive should help create more equal attention to monitoring the quality of care provided, as well as the financial soundness of the organization, where many states focus their attention today.

Q: Shouldn't PSOs be subject to financial standards?

A: Absolutely, which is why we proposed a very specific and significant solvency standard, one more demanding than the current Medicare HMO solvency standard. It is based on the net worth and reserve requirements in the current model HMO act issued by the National Association of Insurance Commissioners, with some limited adjustments.

Q: Why does the NAIC solvency standard have to be adjusted?

A: To reflect the way affiliated providers work together within an integrated delivery system, and to recognize that there are several ways to demonstrate financial soundness, many of which are used today by the states. The bill also ensures that the health delivery assets of a PSO are recognized in calculating net worth as was provided in the NAIC's model HMO act (and related permitted investment rules), but which has been unevenly recognized by the states. [Note: A separate detailed explanation of the solvency requirement, including alternative means, is available.]

Q: Doesn't the NAIC support using its new risk-based capital approach to set PSO solvency requirements? Why not use the new one?

A: Yes, they do, but the approach is still under development and suffers from many problems. So it would be premature to adopt it. Here are some of the problems: (1) it was designed for life insurance companies and adapting it to health organizations has been based on the experience of health insurers; (2) its suitability for all types of health organizations has not been established; (3) the impact of implementing it has not been tested; (4) issues about how it deals with health plans that produce their own services remain unresolved; and (5) PSO issues, such as how to reflect that only a portion of a PSO's revenue is full risk, remain unaddressed. It would be inappropriate to apply it first to those organizations for which it was least designed to apply.

Q: Haste makes waste—won't rapid entry of provider-sponsored organizations into the market yield undercapitalized plans and widespread failures? The federal government would have another S & L bailout on its hands.

A: No. It is presumptuous to assume that a timely regulatory process would yield financially unsound PSOs. It is the appropriateness of the standards, the quality of management, and the quality of enforcement that determines whether plans are undercapitalized. There are many PSOs already in operation around the country that have a great deal of experience in delivering coordinated care. It is these same organizations that not only deliver the care but are often responsible for improvements in efficiency that have contributed to the success of private health plans in their communities. As to potential failures, Medicare already has a structure in place to deal with failure of risk contractors that we believe accomplishes adequate protection of beneficiaries and the Medicare program, and it would apply to PSOs as well.

Q: What are those protections?

A: First, MCOs are required to include provisions in their contracts with providers that are designed to protect beneficiaries from financial liability if the MCO becomes insolvent. These contracts generally cover the bulk of all care delivered, except for out-of-area services and out-of-network emergency care. These same requirements would apply to PSOs—both affiliated and participating providers. The most common contractual provisions are "hold harmless" and "continuation of care" provisions. Under the hold harmless provision, participating providers agree that they will not seek payment from beneficiaries (other than copayments and deductibles) for covered services during a period when premiums were paid to the MCO, even if the MCO fails to pay the provider. Under the continuation of care provision, participating providers agree that they will complete care that is in process for beneficiaries if the MCO becomes insolvent.

Second, the Medicare program protects itself by paying plans on a monthly basis so that the advance payment limits their financial exposure if the plan should fail. If the plan fails, the hold harmless and continuation of care provisions cover both beneficiary and Medicare program liability for all services from contracted providers.

With respect to future care for the enrollees of failed plans, under current rules they can enroll in any other coordinated care plan available from a Medicare risk

contractor in their area under a special enrollment requirement or return to the standard Medicare fee-for-service area. The only ones really hurt by a PSO failure would be the providers themselves.

Q: Would PSOs be subject to the same Medicare consumer protection standards as apply to HMOs and CMPs?

A: Yes, and the bills improve those protections by significantly enhancing the requirements for quality assurance for any risk contractor, including PSOs, that wants a waiver from the 50/50 rule. And PSOs would go further by adopting utilization review approaches that intrude less into the patient-physician relationship by ensuring an integral role for physicians in setting quality and medical management policies and by ensuring fair treatment of physicians when forming networks.

Q: What is the "50/50 rule" and why is it a problem for Medicare PSOs?

A: The "50/50 rule" is an enrollment composition rule which mandates that no more than 50 percent of enrollees in a health plan that contracts with Medicare may be Medicare or Medicaid enrollees. There is a similar requirement under Medicaid, but it is set at 75/25 (that is, no more than 75 percent enrollees can be Medicare or Medicaid enrollees). This rule was adopted as a way to ensure that HMOs/CMPs seeking risk contracts would arrive with managed care experience, and that the presence of commercial enrollees would act as a brake on any incentives to take shortcuts on care, since commercial enrollees would have a better ability to choose another plan in the private sector.

The "50/50 rule" is a problem both for provider-sponsored organizations (PSOs) and for traditional HMOs/CMPs. If it were maintained, otherwise qualified PSOs could not be offered to Medicare beneficiaries. That's because most PSOs don't directly enroll commercial market enrollees. They contract with health plans to provide coordinated care, but the health plan, not the providers actually enroll individuals. Further, it is hard to manage the number of commercial enrollees served when major commercial contracts swing large blocks of enrollees in and out of plans. The "50/50 rule" has not demonstrated much of a role in determining whether an HMO or CMP provides good or bad quality. The PSO bill waives this old "50/50 rule" when plans meet the new higher quality standards and an experience standard that focuses on actual experience delivering coordinated care.

Q: The bills establish enhanced quality standards, but what about the other consumer protections Medicare requires for HMOs and CMPs? Shouldn't they be the same for all beneficiaries?

A: All of the current beneficiary protections will still be in place, including internal grievance procedures, beneficiary appeals processes, and enrollment and marketing requirements. The enhanced quality requirements included in the bills for PSOs and other risk contractors that wish to have the 50/50 requirement waived are in addition to current requirements. Moreover, PSOs that currently rely on case-by-case utilization review—which consumers and doctors find too intrusive—would transition to evaluating patterns of care; they also would guarantee physicians an integral role in setting medical policy, quality, and medical management processes; and they would ensure fair treatment of physicians in the operation of networks.

Q: What are these new quality standards?

A: The new standards are designed to address many concerns that consumers have voiced about managed care. Current Medicare standards are more general, and were written before the country had much experience with quality of care issues under managed care. The additional standards ensure that PSOs evaluate the continuity and coordination of care and monitor possible patterns of under- as well as over-utilization. The organization must take action to improve quality, evaluate the effectiveness of their program, and publicly account for those results.

Q: Even if these quality standards are higher, won't the lack of state licensure mean that HMOs and other risk contractors will be held to a higher standard than PSOs?

A: Generally, no. It is impossible to guarantee that each of these standards will be the same or higher than every requirement in every state. However, the requirements were designed to create high expectations, because we believe PSOs can meet them. That is why PSOs are required to deliver the substantial proportion of the benefit package through affiliated providers. This basic structural requirement, which is **not** required of state-licensed HMOs, should ensure coordination and continuity of care across settings, lessen the need for external management of clinical decisions, and provide greater accountability to the community.

The one area where state standards are more specific, though not necessarily higher, than Medicare regulations is financial solvency. That is why the PSO bills outline a specific standard that was patterned on NAIC's Model HMO Act. In the other areas of consumer protection, Medicare either has its own rules that are spe-

cific to Medicare beneficiaries, like enrollment and marketing and beneficiary appeals, or the standards are very similar to what states require.

Q: How do the bills make rural PSOs a viable option?

A: There are several features in the bills that are important for rural PSOs.

- *Recognizing the value of local providers.* The bill would allow this new type of managed care organization, PSOs, to provide care in communities that have previously been unattractive to other managed care organizations because they have too few enrollees or because payments in these areas are not profitable. PSOs would be comprised of providers already serving those communities, allowing them to provide continuity of care to seniors as they choose a managed care option.
- *Partial Risk Payment.* The bills authorize "partial risk" payment contracts for all Medicare plans. These contracts would provide the entire package of Medicare benefits, but the Medicare program and plan would share financial risk through a payment method that mixes capitation and costs. This is critical when dealing with smaller numbers of enrolled individuals where the law of averages doesn't work, and where rural populations have had significant problems with access to needed services.
- *Reduced minimum enrollment.* The bills lower minimum plan enrollment from 5000 to 1500 overall, and from 1500 to 500 for rural areas. In the Senate bill, the reductions apply to all contractors. In the House bill, they apply only to PSOs.
- *Waiver of 50/50 rule.* PSOs and any other Medicare plan that meets the enhanced quality standards and has demonstrated experience delivering coordinated care, would have the 50/50 rule waived. Important for rural and other PSOs is that this recognizes their experience in delivering coordinated care even though it may have been under contract with MCOs or the Medicaid program. PSOs with no managed care experience would have to get their initial experience outside the Medicare program or as subcontractors to Medicare risk contractors.
- *Rigorous but flexible solvency standard.* The standard for PSO fiscal soundness sets solid, quantifiable net worth and reserve requirements, but it also provides the flexibility of recognizing alternative means to demonstrate the same level of consumer protection against insolvency. Such means include letters of credit, reinsurance, stop loss coverage, and guarantees from financially strong parties such as corporate parents or affiliates. Further, the Secretary can alter the requirements under partial risk contracts.

Basic Changes in PSO Proposals from 1995 to 1997

OVERVIEW

H.R. 475, which would add provider-sponsored organizations to the options available to Medicare beneficiaries, incorporates a variety of changes from the 1995 proposals that were designed to address issues raised in the 1995-96 debate.

Since there were a variety of bills in the 1995-96 debate—with often very different provisions—the list that follows is general in nature and designed to give a flavor for the changes. The attached chart, however, provides a detailed comparison of the 1997 House and Senate PSO bills with the PSO provisions in the 1996 budget reconciliation conference report (ultimately vetoed), the "Blue Dog" Coalition proposal, and the White House proposal. H.R. 475:

- *Adds PSOs to the current Medicare risk contracting program without restructuring that program.* As such it is a more modest proposal which applies current Sec. 1876 Medicare risk contracting rules to PSOs, with only a few revisions (some of which apply to all risk contractors and some of which apply higher standards to PSOs).
- *Restructures and refines the definition of a PSO.* The bill defines and clarifies the difference between a PSO (a broad term commonly used to describe a variety of provider organizations and arrangements) from Medicare qualified PSOs that have the capability to contract to provide full benefit, capitated, coordinated care to beneficiaries. Related definitions are clarified to include more clear criteria for the direct provision of services by affiliated providers and to ensure that all but a small fraction of contracted services are provided under either affiliation or participating provider agreements to ensure that Medicare provider contracting rules, especially those that protect beneficiaries from financial liability in the event of a plan failure, would apply equally to PSOs.
- *Provides a specific PSO solvency standard, rather than just a process for the Secretary to develop a standard.* The bill also includes a specific solvency standard to ensure the fiscal soundness of PSOs which incorporates the curent NAIC

model HMO act's net worth and reserve requirements (slightly adjusted to reflect PSO operations).

- *Provides for enhanced quality standards in response to beneficiary concerns.* PSOs would meet enhanced quality standards, as well as new standards governing utilization review and physician participation in networks.
- *Provides for both federal and state enforcement rather than just federal.* The bill provides for an initial period of federal certification and standards but requires contracts with states during that period to provide more local monitoring of ongoing PSO performance and beneficiary access to services. After the initial four-year period, state licensure would be required if their standards were sufficiently similar to the federal standards. This approach marries the benefit of national standards for a national program with the benefit of the closer monitoring eye of state agencies—the approach currently used by Medicare in certifying the variety of health care providers.
- *Provides a conditional waiver of the 50/50 rule, rather than eliminate it outright.* Any Medicare risk contractor (including PSOs) that (1) meet the enhanced quality standards and (2) demonstrate experience in providing coordinated care (whether directly or under contract with health plans) can have the 50/50 enrollment composition requirement waived. In addition to going directly at the issues that the 50/50 rule addressed indirectly, this approach provides an incentive for current risk contractors to meet the enhanced quality standards.
- *Provides for partial risk as well as full risk payment methods.* While both approaches would contract to provide the full benefit package, the addition of a partial risk payment method (that is, payment based on a mix of capitation and costs) provides several advantages: (1) it expands the ability to provide capitated, coordinated care to smaller rural or chronic care populations, (2) it provides a means of transitioning away from cost-based HMOs/CMPs, and (3) it ensures that the Medicare program shares in the savings from efficiencies.
- *Provides for a moderate approach to preempting state anti-managed care laws that balances plan and consumer interests.* The bill preempts state anti-managed laws, but only to the extent that they prohibit the use of standard managed care techniques such as utilization review, incentives to use network providers, negotiation of provider payment arrangements, the use of gatekeepers, and the corporate practice of medicine. Unlike last year's proposals that would have also preempted any state limitations on these practices, the bill specifically clarifies that its provisions are not intended to prohibit a state from regulating or limiting abusive arrangements or practices that act inappropriately to withhold, limit, or delay access to covered services.
- *Provides for reconciliation of the Medicare risk contractor requirement for coverage of emergency services with the requirements of the federal Emergency Treatment and Active Labor Act (EMTALA).* The bill clarifies that all Medicare risk contractors, including PSOs, must cover the cost of screening and stabilization in any hospital emergency department, and must provide for expedited review (24 hours a day, 7 days a week) if prior authorization is required for treatment following screening and stabilization.

Comparison of 1995 Medicare Reconciliation
Proposals (PSO Provisions) with 1997 Senate and House Proposed
Provider-Sponsored Organization Acts
January 28, 1997

(* Italicized word in the 1997 proposals indicate the provisions apply to both PSOs and other risk contractors.)

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
GENERAL	Specifically includes qualified provider-sponsored organizations (PSOs) as a new Medicare risk contracting option.	Specifically includes provider-sponsored organizations (PSOs) as a Medicare Plus option.	Specifically includes provider-sponsored organizations (PSOs) as a Medicare Choice option.	Specifically includes provider-sponsored organizations (PSOs) as a managed care option under Part C.
DEFINITION	PSOs are defined as public or private providers, or groups of affiliated providers that can contract on a capitated basis for the full Medicare benefit package. The PSO must be capable of providing directly the "substantial proportion" of services (significantly more than the majority of the Medicare benefit package and most of the remainder of contracted services under written agreements with non-affiliated providers) through affiliated providers. "Affiliation" status defined as common ownership, common control, or substantial shared financial risk. In applying the substantial proportion test, the Secretary shall consider the need for providing a limited proportion, for example, emergency services or out-of-network services, through providers not affiliated or under contract, and may vary the proportion based upon relevant distinctions, such as their location in an urban or rural area.	PSOs are defined as public or private providers, or groups of affiliated providers, that can contract on a capitated basis for the full Medicare benefit package and deliver the "substantial proportion" of covered services through affiliated providers. "Affiliation" status defined as common ownership or control but not substantial shared financial risk. PSO definition also requires that affiliated providers who share substantial risk must have at least a majority financial interest in the entity. "Substantial proportion" would be defined by the HHS Secretary in regulations and must take into account the need for financial stability and integration of providers, as well as the need to vary the proportion based on relevant factors such as rural or urban settings.	PSOs are defined as public or private providers, or groups of affiliated providers, that can contract on a capitated basis for the full Medicare benefit package and deliver the "substantial proportion" of covered services through affiliated providers. "Affiliation" status requires common ownership, common control, or substantial shared financial risk. "Substantial proportion" would be defined by the HHS Secretary in regulations and must take into account the need for financial stability and integration of providers, as well as the need to vary the proportion based on relevant factors such as rural or urban settings.	PSOs are defined as a hospital, a group of affiliated hospitals, or an affiliated group consisting of a hospital or hospitals and physicians, that can contract on a capitated basis for the full Medicare benefit package. PSOs must also deliver a substantial portion of the Medicare benefits directly (may vary for rural or underserved areas), at a minimum, physician and inpatient hospital services.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
PAYMENT BASIS/RISK ASSUMPTION	The payment method and rate for provider-sponsored organizations would be determined by the type of risk arrangement entered into with Medicare: - PSOs contracting on a full risk basis would be paid on the same basis as HMOs/CMPs. - *For PSOs or other risk contractors that enter partial risk arrangements, the PSO would be paid a blend of capitation and cost reimbursement or any other methodology agreed upon by the Secretary and the organization.* The Senate bill also requires HHS to report to Congress after four years on experience with partial risk contracts.	Full-risk capitation, paid on same basis as other Medicare Plus options No partial risk option.	Full-risk capitation paid on same basis as other Medicare Choice options HHS Secretary also required to conduct a partial capitation payment demonstration and submit report to Congress with recommendations on alternative provider payment approaches including packaging, pricing, partial capitation and risk-sharing	Full-risk capitation paid on same basis as other managed care plans Includes a partial capitation option for plans that maintain non-Medicare and non-Medicaid enrollment of 1500 and show themselves capable of bearing risk.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
REGULATORY STRUCTURE	All standards are set at the federal level Medicare contracts with PSOs would not require, and states would be preempted from requiring, state HMO or insurance carrier licenses for at least the first four years During that time, HHS would certify PSOs, but would contract with states to monitor ongoing PSO performance and beneficiary access to services Beginning January 1, 2002, the state licensure requirement would be reinstated in any state whose PSO licensure requirements were, in the case of solvency, identical and, in the case of all other standards, substantially equivalent Preemption of state licensure would be applicable only with respect to Medicare enrollees.	All standards are set at the federal level Enforcement occurs through state licensure only after the state has been approved as conforming to the federal standards Until then, certification occurs at the federal level, preempting state licensure Approval of state licensure for PSOs is split into two separate processes one for all non-solvency standards; and one for solvency If state is approved for one, but not the other, PSOs would go through both state licensure and federal certification.	Includes a complex structure of exceptions to the federal requirement that Medicare Choice organizations be state licensed, and of preemptions of state regulatory authority for PSOs specifically and for all Medicare Choice organizations generally For PSOs, they are not required by Medicare to be state licensed until after 1/1/2000 and then only if the state's standards are identical to the permanent federal standards. State law is superseded (i e , preempted) on a narrower basis (1) for initial capitalization and financial reserves, and (2) areas of direct conflict.	Includes limited preemption of state law for PSOs

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
REGULATORY STRUCTURE (cont.)	Even after a state is approved to take over enforcement, PSOs may seek a waiver of the requirement to be state-licensed if the state failed to act on a completed ("received" in the House bill) application within 90 days or denied application and it applied standards in a discriminatory manner. Waiver lasts for 24-months and may be renewed. Waiver ceases to apply if the state licenses the PSO within the 24-month period.	Even after a state is approved to take over enforcement, PSOs and all other Medicare Plus organizations each have the ability to seek a waiver of the requirement that they be state-licensed if the state failed to act on a completed application within 90 days, or it applied standards in a discriminatory or inappropriate manner. Such waivers last no more than 36-months, during which state licenses must continue to be sought. Waivers are renewable if the problems persist.	No waiver provision.	PSOs required to be state licensed if the state: (1) Has solvency standards that are substantially equivalent to the federally developed standards; (2) Issues licenses on a timely basis; and (3) Applies non-solvency standards uniformly to all kinds of plans including PSOs. Presumably if a state does not meet these requirements, state law is preempted and the PSO could seek federal certification
	In the House bill the Secretary may deem compliance with these standards or any portion of standards for those PSOs that are accredited by a private accreditation organization acceptable to the Secretary. The Senate limits its "deemed status" provision to quality assurance requirements.	"Deemed status" provision limited to quality assurance requirements.	Secretary will recognize private accreditation for relevant portions of the PSO standards where they are stringent.	"Deemed status" provision limited to quality assurance requirements.
	Secretary may impose user fees for federal certification process.	Federal imposition of user fees to pay for initial certification appears erroneously limited to Taft-Hartley and union plans.	Secretary shall establish a process for Choice plan certification and charge user fees.	No provision for Secretary to establish plan certification process or charge user fees.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
STANDARDS DEVELOPMENT	Secretary shall issue interim regulations for PSOs within 180 days of enactment. Interim regulations will be effective through December 31, 2001. Permanent standards issued not later than July 1, 2001. In developing both interim and final standards, the Secretary shall consult NAIC, American Academy of Actuaries, State health departments, associations representing provider-sponsored organizations, quality experts (including private accreditors) and Medicare beneficiaries No distinction between standards development for quality and solvency. Note: Because the proposals maintain most of the current Medicare risk contracting standards and additional requirements or revisions to current standards are fairly specific there is less need for separate quality and solvency processes.	Standards development split into two pieces--one for all standards applied to state-regulated Medicare Plus plans and non-solvency standards for PSOs, and the other for PSO solvency standards. The Secretary must ask NAIC to develop the proposed standards for the first group, subject to review by the HHS Secretary. This results in almost common standards for all plans, including: quality assurance (which includes AHA's recommended quality enhancements), access, beneficiary information, enrollment practices, and grievance procedures. The key exceptions are the minimum enrollment and solvency standards for PSOs, and limited applicability of certain standards to FFS plans. PSO solvency standards would be developed under the House-defined negotiated rulemaking process. HHS Secretary must consult with National Association of Insurance Commissioners (NAIC), American Academy of Actuaries, Medicare beneficiaries, and interested parties in developing proposed PSO solvency standards.	Secretary shall issue interim regulations for Medicare Choice organizations (including PSOs) within 180 days, soliciting views of the American Academy of Actuaries for solvency standards to be effective through 1999. Permanent standards, developed in consultation with the National Association of Insurance Commissioners, associations representing various types of Medicare Choice organizations, and beneficiaries will be promulgated to be effective 1/1/2000. The standards for almost all Medicare Choice organizations and products are the same, including: quality assurance (which includes AHA's recommended quality enhancements), access, beneficiary information, enrollment practices, and grievance procedures. The primary exception is the minimum enrollment requirement and, potentially, the solvency standards. Standards developed by the Secretary to protect against the risk of insolvency must take into account the nature and type of Medicare Plus product offered by the organization.	Current regulations or those available in proposed form on December 31, 1996 will apply to all Part C plans, unless they are inconsistent with this proposal. Secretary may issue regulations before 1998 for Part C on an interim final basis. No other process outlined for developing regulations for Part C managed care organizations except for solvency standards for PSOs. Note: This lack of detail could be due to the fact that the other standards are very similar to current Medicare risk contracting requirements. Solvency standards for PSOs would be developed by the Secretary in consultation with the NAIC, organizations that provide or pay for health care services, and consumer organizations and published as an interim final rule by July 1, 1996. Other managed care plans will need to meet federally qualified HMO solvency standards.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
START-UP TIMING	Federal interim standards to be published 180 days from enactment. Effective as of contract year 1998, through December 31, 2001 Final standards implemented 1/1/2002	Same as House but only federal solvency standards would be established through a shortened negotiated rulemaking process involving ■ a proposed rule published by 45 days after enactment; ■ a short public comment period (15 days); ■ appointment of a committee to negotiate consensus among representatives of NAIC, American Academy of Actuaries, Medicare beneficiaries, and interested parties, on a recommended rule ■ publication of an interim final rule by September 1, 1996, with at least 60 days for public comment. ■ final rule publication no later than September 1, 1997 ■ proposed PSO solvency application forms must be made available by March 1, 1996. PSO non-solvency standards are now combined with all standards for other Medicare Plus plans under a different process: ■ Interim rules to be published by June 1, 1996 ■ NAIC development of proposed federal standards by 12 months after enactment. ■ HHS Secretary compares NAIC proposal to statutory requirements for consistency and promulgates federal standards no later than 60 days after receipt from NAIC State-licensed plans would be able to market to beneficiaries much earlier through the combination of ■ deeming state licensure to fulfill general Medicare Plus requirements on an interim basis (1996 and 1997); and ■ adopting a "file and use" approach to benefit package design, cost sharing policies, premium rate setting etc., which would allow their use on an interim basis if the Secretary did not reject them within 60 days.	Federal, interim standards to be published 180 days from enactment Effective through 1999 Final standards implemented 1/1/2000	No process outlined for start-up, except for publishing solvency standards for PSOs as an interim final rule by July, 1996. Current HMO/CMP Medicare risk contractors eligible under current requirements until 2001

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
SOLVENCY	The PSO must be fiscally sound. Fiscal soundness demonstrated by meeting specified net worth and reserve requirements or through specified alternative means. Net worth and reserve requirements drawn from NAIC model HMO Act. Net worth not less than the greater of: -- $1.5 million at time of application and $1 million thereafter, -- the sum of 8 percent of the costs of care not provided directly by organization or affiliated providers, and 4 percent of estimated costs of services provided directly by the organization or its affiliated providers; or -- 3 months of uncovered expenditures. In applying statutory accounting principles to determine net worth, admitted assets would include: delivery assets, government receivables due for more than 90 days, and other assets the Secretary chooses. Also recognized, as a contribution to surplus, would be amounts received under subordinated debt. (Secretary has authority to alter requirements for partial risk arrangements.) Adequate claims reserves, using statutory accounting principles and certified by an independent actuary;	Standards developed by the Secretary to protect against the risk of PSO insolvency must take into account: (1) a Medicare Choice plan's delivery system assets and its ability to provide services directly to its enrollees through its affiliated providers, and (2) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees from a financially strong party, organizational insurance coverage, partnership with a licensed entity, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.	Secretary shall recognize multiple means of demonstrating solvency including: (1) reinsurance purchased through a vendor or a captive company owned directly or indirectly by 3 or more PSOs, (2) unrestricted surplus, (3) guarantees, and (4) letters of credit. Secretary may treat as admitted assets, the assets used by a PSO in delivering covered services	Secretary shall develop solvency standards for PSOs. Other risk contractors will need to meet federally qualified HMO solvency standards. No guidance in the proposal on alternative means for PSOs to demonstrate solvency.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
QUALITY ASSURANCE	In addition to current quality assurance standards, PSOs would meet enhanced standards for quality assurance programs, including that they: - stress health outcomes; - provide opportunities for input by physicians and other health care professionals - monitor and evaluate high volume, high risk services, and both acute and chronic conditions; - evaluate continuity and coordination of care; - have mechanisms to detect both over-and under-utilization; - after identifying areas for improvement, establish or alter practice parameters; - take actions to improve quality and assess the effectiveness of these actions through systematic follow-up; and - evaluate the effectiveness of their quality program. In addition, PSOs would be required to make available information on designated quality and outcomes measures to facilitate beneficiary choice. If a PSO uses case-by case utilization review, it must base review on current medical practice standards and transition to focusing on patterns of care. PSOs must consult with physicians regarding the PSOs medical policy and quality management procedures and must establish processes regarding physician selection for written notice and the ability to appeal adverse decisions.	Plans (except FFS plans) must have quality assurance programs that include: written protocols for U.R., review by physicians or other health professionals, monitoring of potential over-and-under utilization, evaluation of continuity and coordination of care, assessment of effectiveness of QA program and provision of comparative indicators to Medicare FFS including disenrollment rates, enrollee satisfaction, and health outcome data as it becomes available.	Same as Conference. Secretary may require annual plan reports on quality, outcomes, and other factors about enrollees and treatments provided. Secretary to conduct demonstration projects to assess the cost, benefits, and impact of disseminating information on plan performance, including value of Medicare supplemental policy performance.	Plans must have quality assurance process that focuses on health outcomes and includes review by physicians or other health professionals. Secretary, in consultation with managed health care plans (including PSOs), consumer groups, and purchasers, to develop by 7/1/97 a quality measurement system to collect information on outcomes and quality. This system will replace 50/50 enrollment requirement when implemented.
QUALITY ASSURANCE (cont.)	The Secretary may deem compliance with the quality standards for those organizations that are accredited by private accrediting bodies accepted by the Secretary	All types of plans can use private accreditation organizations to meet QA requirements. Plans must make arrangements with independent organizations for external quality review.	Same as Conference.	Same as Conference and Coalition.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
EMERGENCY ROOM COVERAGE	*The House and Senate bills differ. The House bill requires PSOs and other risk contractors to cover, without prior authorization, screening to determine if an emergency medical condition exists and stabilization for the condition. The Senate has no provision.* *For other services subject to prior authorization, the House bill requires an expedited process be available 24 hours a day, 7 days per week. The Senate has no provision.*	Emergency medical services covered with no prior authorization. Emergency medical services defined as immediately needed treatment for an injury or sudden illness if time required to reach network provider would mean risk of serious damage to patient's health. No expedited prior authorization required for other care delivered in the ER setting. Secretary will contract with outside entity to review and resolve denials related to urgent or emergency services.	Emergency services covered with no prior authorization. Emergency services are services furnished in a hospital emergency department for a medical condition considered an emergency by a prudent layperson. No expedited prior authorization required for other care delivered in the ER setting. Plans must have an expedited appeal process for emergency situations. No requirement for outside review.	Out-of-network services reimbursed if required immediately because of an unforeseen illness, injury, or condition. No provision specific to emergency situations No expedited prior authorization required for other care delivered in the ER setting. Plans must have an expedited appeal process for urgent situations. No requirement for outside review
SUNSET OF FEDERAL CERTIFICATION	As of January 2, 2002, states can take over enforcement if their licensure program uses identical solvency standards and standards in other areas are substantially equivalent. Federal certification would remain available for PSOs in non-approved states or for PSOs that have received a waiver of the state licensure requirement.	Federal certification would remain available for Medicare Plus organizations in non-approved states or for Medicare Plus organizations that have received a waiver of the state licensure requirement.	As of 1/1/2000, states can take over regulation of PSOs only if their licensure program and enforcement is identical to HHS'. Federal certification would remain available for PSOs in non-approved states.	Federal certification process is only implied. PSOs are required to apply for state licensure within certain federal parameters. Therefore, proposal does not include a sunset of federal certification.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
ENROLLMENT COMPOSITION	The House and Senate bills differ. In the House bill, the alternative minimum enrollment levels of 1500 or at least 500 in rural areas would only apply to PSOs. PSOs would have three years to meet these enrollment levels. *In the Senate bill, these alternative minimum enrollment levels would apply to <u>all</u> risk contractors*	Minimum enrollment for PSOs lowered to 1500 (or 500 for those primarily serving individuals that reside outside of urban areas). Retains current HMO minimum enrollment levels of 5000 (or 1500 for rural) for other Medicare Plus options.	Same as Conference regarding minimum enrollment levels.	Retains current minimum enrollment levels of 5000 (1500 for rural areas.)
	The 50/50 rule would be waived for any Medicare plan that can demonstrate it is capable of providing coordinated care (through compliance with the enhanced PSO quality standard, except the utilization review provisions) and have experience in providing coordinated care through health plans	The 50/50 rule is eliminated for all plans. No standards are established to replace the 50/50 enrollment requirement.	Retains 50/50 requirement with an exception for PSOs if commercial payment exceeds Medicare Choice payment, or under limited conditions for public providers, or providers in areas where more than 50 percent of the population is eligible for Medicare or Medicaid.	Retains the 50/50 requirement, with exceptions for all plans. Exceptions allowed to the 50/50 rule include: (1) area with more than 50% of population Medicare-eligible, (2) waiver for three years for governmental entities, (3) underserved rural area, (4) contractor who meets other enrollment standards and has a good compliance record for three years, and (5) contractor with good record in other areas. The 50/50 requirement will be waived for all Part C managed care organizations when the quality measurement system which is to be proposed by 7/1/97 is implemented.

ISSUE	1997 HOUSE AND SENATE PSO ACT	CONFERENCE AGREEMENT	COALITION PROPOSAL	WHITE HOUSE PROPOSAL
APPLICABILITY TO MEDICAID MANAGED CARE	Permits states to recognize PSOs as qualified coordinated care entities under Medicaid	No provision recognizing Federal certification of PSNs for Medicaid purposes. Medicaid managed care requires state licensure. Requires Medicaid plans to adhere to same state solvency requirements as private sector health plans and providers, unless MediGrant program adopts alternative standard. Public organizations exempt if state guarantees organization.	Provider-sponsored networks are specifically included as eligible managed care providers. Secretary shall establish solvency standards and take into consideration standards applicable to Medicare risk contracts	Current law, which gives states flexibility in determining eligible managed care entities
BARRIER REMOVAL	Anti-trust -- The House bill requires that DOJ and FTC publish explicit guidelines and makes those guidelines binding on federal enforcement and guidance to state enforcement of state antitrust laws. The Senate bill does not include a similar provision.	Anti-trust -- Deleted due to "Byrd rule": (1) Provision providing "rule of reason" analysis instead of "per se violation" (limited protection) for formation of PSOs and for non-financially integrated groups to contract with PSOs; (2) Provision providing exemption for activities of medical self-regulatory entities.	Anti-trust -- Provision providing "rule of reason" analysis for "provider service networks" contracting to provide PSO services; Attorney General to issue anti-trust guidelines for health plans; Review process to grant anti-trust protection ("health care certificates of public advantage") to appropriate "health care collaborative activity." Exception for small merger and allocation agreements that meet specific conditions.	Anti-trust -- No provision
	Pre-emption of certain anti-managed care laws -- The House bill preempts state laws that prohibit the use of managed care techniques but preserves the right of states to regulate or limit abusive arrangements or practices that inappropriately act to withhold, limit, or delay access to covered services. The Senate bill does not include a similar provision.	No provision	No provision	No provision.
	Note: Several Medicare reconciliation proposals also addressed fraud and abuse and malpractice reform. The PSO proposals do not contain malpractice reforms. Several of the fraud and abuse issues were addressed in the Kassebaum/Kennedy legislation.			

Mr. BILIRAKIS. Thank you, sir.
Mr. Greenwood.

STATEMENT OF HON. JAMES C. GREENWOOD

Mr. GREENWOOD. Mr. Chairman, I'd like to also thank you for holding this hearing and thank all of my colleagues on the Health and Environment Subcommittee for being here. You look so much more impressive from this perspective.

I would also like to introduce my guest, Richard Rief, who is the CEO and president of Doylestown Hospital in my district. It's a hospital that has developed a PSO in the commercial market very successfully. Its biggest customer is the Central Bucks School District, and I believe already the school district has achieved something like $3.3 million in savings by using the hospital PSO.

I would ask, Mr. Chairman, that I could submit my statement for the record and just summarize.

Mr. BILIRAKIS. Without objection.

Mr. GREENWOOD. I would begin by saying that I think the members, in their opening statements, have identified all of the relevant issues that we have to deal with in this PSO or PSN legislation.

I would stipulate that the Chairman's chart is exactly on point. Our first and foremost responsibility is to the Medicare beneficiaries. We should not pass this legislation unless it gives them at least as good if not a better deal than they have now, as an option, and with all of the safeguards and protections that they now enjoy. And, of course, we have an obligation to the taxpayers to make sure that their hard-earned dollars are spent wisely for Medicare.

Inside the oval there, I guess we will find some battles going on between the health care industry, the insurance industry, and the doctors and hospitals. Our responsibility here must be to make sure that they have a level playing field, that we do nothing that favors one side of that competitive market that we're trying to create over the other.

We had a very contentious debate in the last Congress. There were a lot of things that we couldn't agree on, but I think there were some things that we all agree on. We all agree that, under the present trend lines, Medicare goes bankrupt in 4 or 5 years. We all agree that we need to achieve significant savings in the near future, at least $100 billion over the next 5 years or so.

We all agree that managed care, as a choice for coordinated care, as a choice for Medicare beneficiaries, is a critical means to achieving those savings. And I think, frankly, that there is very wide agreement that PSOs are one of the options that should be included.

This was in the Republican Medicare reform proposal that Congressman Hastert and I, and the Chairman and others, were involved in crafting. It's in the blue dogs' Medicare proposal, and it's in the President's proposal this year, I believe. So that we ought to go forward with some sort of PSO option for Medicare beneficiaries is really not subject to a great deal of debate. What is, of course, is what the standards are and whether the State or the Federal Government regulates these organizations, and that's what we need to resolve.

I think the benefits of PSOs are fairly obvious. They are community-based. They are a local option, where a lot of our senior citizens will feel most comfortable. From the perspective of both the patient and the physicians, there is no intermediary between them when they are providing the health care that the seniors need.

This debate is somewhat like the debate that occurred 20-some years ago when HMOs were first trying to get into the market, and they came to the Congress saying, "We need Federal law to supersede State law, which is serving as a barrier to our opportunity to offer a unique way of providing health care coverage."

The Congress, I think it was in 1973, agreed and passed the HMO Act that recognized that there are, in fact, unique differences between HMOs and insurance companies, fee-for-service insurance companies, and the rest is history and I think, as we look at it today, cost containment in the health care field throughout the country.

Solvency is a major issue, and our proposal simply suggests that health care delivery assets be considered when determining the solvency requirements for a PSO. The fundamental difference is that an insurance company needs cash to provide health care. The only thing it has to offer back to the providers is cash. A PSO has all of the doctors and the hospital, and the surgical equipment, and that "sweat equity," as it has been referred to. The physical assets of the hospital and all of its components need to be considered when determining the solvency requirements.

I believe that Congressman Stenholm and I have offered a good bipartisan approach to this concern. I hope that the subcommittee will consider it seriously. My expectation is that Medicare reform will be an early agenda item of this Congress, and hopefully we can craft a PSO piece of it as part of our overall Medicare reform efforts.

I yield back.

[The prepared statement of Hon. James C. Greenwood follows:]

PREPARED STATEMENT OF HON. JAMES C. GREENWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

We have declared as a top priority—the need to reform and safeguard the future of the Medicare program. Given our commitment to balancing the budget within this context, the use of coordinated care under the Medicare program is being encouraged by the Administration and this Congress. For Medicare beneficiaries, choice of plans and the ability to choose local providers are critical. I am testifying before you today as a Subcommittee member and sponsor of a Medicare provider-sponsored-organization bill to amplify my conviction that PSOs can help meet *both* the cost containment objectives envisioned in the federal budget process *and* the *need* for beneficiaries to have greater choice and greater quality.

Provider-sponsored organizations are not a new concept. The House and Senate successfully passed PSO legislation in the 104th Congress with broad support. Little opposition exists to expanding Medicare's managed care options to include PSOs. However, agreement on the standards for PSO participation have been more elusive.

That is why we are here today. You will hear testimony from the indemnity insurers who want (quote) "a level playing field." Their opposition will be undeviating. You will also hear testimony from the providers and hospitals who will argue that PSOs should be held to requirements that are sensitive to the many differences between PSOs and HMOs. Needless to say, I agree. Such Medicare requirements should reflect, for example, that PSOs are the direct providers of care; not the insurers who purchase the care.

The NAIC will testify about its efforts to develop a model uniform standard for all managed care plans, which some may argue, provides a sound reason for Congress *not* to take action on PSOs. I commend the NAIC and encourage the comple-

tion of this model. The problem is that we are reforming Medicare *now*. We are balancing the budget *now*. PSO legislation is a federal, temporary measure that is *essential* if we encourage vigorous managed care enrollment in Medicare in order to control costs and reap the savings necessary to balance the budget.

A provider-sponsored-organization will testify on behalf of the managed care community to demonstrate that PSOs can effectively enter the market. *Yes,* they can—and Mr. Rief, President of Doylestown Hospital in my district, can also vouch for their success. Mr. Rief has developed several PSO versions like this. Understand though, that for a PSO to be successful in the current market, it must either contract with large self-employed groups or partner with a managed care company. Not all providers—particularly in underserved and rural areas—have the infrastructure and resources necessary to reconfigure themselves to look like an insurance company. In addition, partnering with an insurance company will not necessarily save Medicare dollars. Let me tell you why. I'll give you two real world examples.

Mr. Rief's hospital and medical staff created the Bucks County Physician Hospital Alliance in 1989 with the specific intent to coordinate patient care. Because of state requirements, his PSO has only been able to provide health services to two large self-insured employers, most notably the Central Bucks School District. In the past four years the physician/hospital plan called Doylestown Choice has enrolled 489 members and their families, and saved the school district $3,332,000. The PSOs savings are the result of an enrollment reduction in an indemnity insurer whose profits and overhead were estimated to be in the 30% range, and for the physicians, hospital and school district's efforts to carefully coordinate the patient's care.

I have another PSO in my district that contracts with an insurer. PennCARE is a regional network of 9 hospitals and medical staff—established after extensively negotiating with a managed care company—that provides all patient care at financial risk for more than 80,000 covered lives. For the Medicare lives covered, the managed care company receives 95% of the AAPCC; but pays its providers at much lower rates. The managed care company benefits from 20% to 25% in profits and overhead. Putting this into a Medicare context, without provider access to Medicare recipients, many dollars would be drained from the Medicare program by the insurer. PSOs that contract with Medicare directly can save money that would otherwise remain with the insurer as profit and overhead. The savings don't necessarily materialize when a PSO is partnered with an insurer.

If we are to truly solve the Medicare crisis we need fundamental change, not only in the amount of financing but in the way care is paid for and provided. This is why we need PSO legislation with federal regulation.

There are so many things I want to share with you about PSOs and the merits of our bill. Since we have a number of witnesses anxiously waiting to give their testimony today, let me just leave you with a few thoughts.

First: PSOs must have federal standards for the first few years because seniors—who rely on the federal Medicare program—should have a federal guarantee of quality and solvency. This does not mean fewer standards or lower standards—it means uniform standards. Rather than relying on highly variable and often limited state requirements, these federal standards assure that state-of-the art quality improvement processes will be available across the country for Medicare beneficiaries who choose the PSO option.

Second: Be clear that we are examining the regulatory nature of PSOs only in relation to the Medicare population. Proponents are not asking for special standards for the commercial market. What we are talking about is devising federal standards for the federal Medicare program.

Third: The Administration, this Congress, and even this Subcommittee has begun to focus on quality of care—especially in the Medicare program. Given this precedent, successful Medicare PSO legislation demands experience. Congress will not allow providers to enter the Medicare market who are inexperienced or who cannot meet high quality and solvency requirements. Again, to ensure this, federal, uniform standards are critical,

Fourth: To an extent, the debate over PSO regulation echoes the debates of the early 1970s when HMOs were just beginning to evolve—but couldn't get into the market. HMOs sought relief from state insurance laws because state solvency requirements were seen as excessive and unappreciative of the unique resources available to them. In their view, these laws needed to be superseded by federal requirements that would encourage proliferation—as opposed to creating a barrier to market. The outcome of this debate was the Health Maintenance Organization Act of 1973, which enabled HMOs meeting federal requirements to be exempt from specific state laws, specifically laws that required the HMO to meet the state solvency requirements.

As of February 1, 1997, nearly 5 million beneficiaries were enrolled in a total of 336 managed care plans. This accounts for only 13 percent of the Medicare population. As Congress and the Administration compromise on a Medicare reform plan that encourages managed care in the name of cost containment and balancing the budget—it is essential that Medicare offer more choices. As managed care grows and as providers integrate and establish coordinated care organizations, Medicare beneficiaries should have the opportunity to receive their health care services from a locally-based provider-operated health plan. I am extremely pleased to have introduced *bipartisan* legislation, with my colleague Mr. Stenholm, that will give Medicare beneficiaries the opportunity to receive their health care services from a locally-based, provider health care plan.

Crafting legislation requires accommodation. Our bill takes a middle of the road approach that builds on last year's compromises. We have met with, and continue to meet with providers, hospitals, insurers and managed care plans to seek their guidance and request their input. All of the major budget proposals, both Democrat and Republican, contained PSO language. This alone, is indicative of the fact that we need to expand the range of coordinated care choices in the Medicare program *if* we are going to save it for future generations.

Thank you for your time and attention.

Mr. BILIRAKIS. Thank you, Jim. On behalf of the panel, I welcome your constituent, the gentleman from Doylestown, is it? I thank both of you for your hard work over the years, and particularly as far as this legislation is concerned.

I don't think it's a good idea to question these gentlemen, because we're not going to get into these other panels.

Mr. HASTERT. Just a quick comment.

Mr. BILIRAKIS. Without objection, a quick comment.

Mr. HASTERT. The gentleman from Texas is more modest than probably should be about saying he never worked on health care. I seem to remember sitting in a hot room most of one July, coming up with a health care bill that you were very, very instrumental in. So, I mean, modesty goes so far, but the truth is out there.

Mr. BILIRAKIS. I think he said he has never served on a health care committee, but God knows, you've worked on health care over the years.

Mr. STENHOLM. Thank you, Mr. Chairman, for paying attention.

Mr. BILIRAKIS. We've worked together.

Somebody better pay attention.

Mr. STENHOLM. I thank the gentleman for his comment.

Mr. BILIRAKIS. Very quickly, Anna. I don't want to——

Ms. ESHOO. Just a quick question of Mr. Stenholm. You mentioned in your testimony that you saw a role for insurance companies to play in this issue. Can you just briefly describe what that would be?

Mr. STENHOLM. Reinsurance, coinsurance. You know, as Jim mentioned in his summary here, the strength of the PSO is the fact that you're putting basic control in the hands of the providers: the doctors, the hospitals, the people that deliver the service. But you also have the risk, and that's where there are many ideas that we've kicked around regarding solvency, not just for entities, but also for individuals.

Ms. ESHOO. But they would be the—your idea, as expressed, is that they would be buying insurance from someone.

Mr. STENHOLM. Sure.

Ms. ESHOO. The insurance companies would not be the key player, is there not——

Mr. STENHOLM. No. That is correct.

Ms. ESHOO. [continuing] other providers——

Mr. STENHOLM. This legislation provides a competitive entity, but we also, I believe, will find that there will be a role to play in the solvency of some form of insurance that would be readily sold.

Ms. ESHOO. So it would be business for insurance companies, because these organizations would be buying insurance from them, but the insurance companies would not have a hand in the health care determinations.

Mr. BILIRAKIS. All right.

Ms. ESHOO. Thank you.

Mr. BILIRAKIS. I don't want to back off from my original comment that I don't want too much time to be taken up by this first panel.

Now, Greg, if you have something very quickly, let's do it, but I don't want to create a precedent here.

Mr. GANSKE. Mr. Chairman, I'd like to have the opportunity to ask a few questions of the authors of the bill about some specifics.

Mr. BILIRAKIS. Well, we're in the process of generally looking into this overall issue. The next two panels will do that for us, not specifically addressing this particular piece of legislation. That's not the point, really, of the hearing here today, and that's the only reason we're not going into that.

Mr. GANSKE. If I could just ask one question of Mr. Greenwood, then.

Mr. Greenwood, there have been some PSOs organized around the country, and they seem to be functioning. There may even be some in your own district. Why would they think that there's a need for Federal legislation?

Mr. GREENWOOD. Mr. Chairman, in answering that question, I wonder if it would be appropriate for me to ask Richard Rief to maybe——

Mr. BILIRAKIS. As long as we do it quickly.

Mr. GREENWOOD. Okay. We'll do it quickly. I think Mr. Rief could probably answer Congresswoman Eshoo's question a little bit about how insurance plays a role in his PSO, and maybe he could respond to Dr. Ganske's question, briefly, as well.

Mr. RIEF. To the first comment about the reinsurance, yes, we do. We have provisions for catastrophic claims, and we do reinsure for that. We also use some of the claims management services that come out of a managed care entity. We have, at this point, early on, used some of their utilization standards, but we have the opportunity to modify those, and that's where it's most critical.

I think, Congressman Ganske, I think that's what this is all about is the opportunity for face-to-face relationships between the patient and the physician, the hospital, and other providers. That's really the essence of this. It's a way to coordinate the care. Right now it is totally fragmented. There's no effort whatsoever to coordinate the care. We need to be able to do that.

Mr. GREENWOOD. The other part of your question, Congressman, is that the need for Federal regulation, as opposed to State regulation, is, first of all, required to make sure that there is uniformity for all of our senior citizens across the Nation, at least until this thing gets up and running, for the next 4 or 5 years.

And then the issue of timing. We think it's an option that needs to be made available very quickly. We have concerns that, if we

rely on the State regulators to license and certify PSNs, that years will go by before this option is available to our seniors. The Federal Government could do it right away.

Mr. BILIRAKIS. Thank you, Jim. Thank you very much, gentlemen.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The second panel will consist of William F. Bluhm, vice president, health, the American Academy of Actuaries. He is chairman of the Health Organizations Risk-Based Capital Task Force and chairman of the Solvency Work Group.

Mr. Glenn Pomeroy, a very familiar name to all of us, he is the brother of one of our members. He is not here. He had to leave, did he?

Mr. Pomeroy is insurance commissioner for North Dakota and vice president of the National Association of Insurance Commissioners. He is accompanied by Mr. David Randall, deputy director, Department of Insurance, for the State of Ohio.

Welcome, gentlemen.

Mr. Bluhm, why don't we kick it off with you.

I think maybe we will ask you to hold your testimony to 10 minutes. We will give you an extra 5 minutes because of the significance of what we might learn from you.

STATEMENTS OF WILLIAM F. BLUHM, VICE PRESIDENT, HEALTH, THE AMERICAN ACADEMY OF ACTUARIES; AND GLENN POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, AND VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, ACCOMPANIED BY DAVID RANDALL, DEPUTY DIRECTOR, DEPARTMENT OF INSURANCE, STATE OF OHIO

Mr. BLUHM. Thank you, Mr. Chairman. I suspect it won't take 10 minutes for me to get through.

I thank you today for inviting the American Academy of Actuaries to come and give you our comments regarding the regulation of solvency for PSOs. The Academy has been very involved with this issue for a lot of years. It represents the actuarial profession in providing unbiased advice to you to help with the technical issues that come out of these sorts of issues.

The fundamental hypothesis that the Academy has worked under, in this regard, is that protection of the public is what should drive these issues, similar to your exhibit. That is the working premise that we used when we developed the health organizations risk-based capital formula that we recommended to the NAIC, at their request.

That formula provides a basis for determining appropriate minimum and target capital standards for all sorts of risk-takers in the health insurance area. Currently, there are a number of capital standards that are in effect for different sorts of risk-takers, and those standards vary, sometimes based on even which department of a State government regulates the entities.

So part of our process was to develop a standard which could apply to all sorts of entities, including PSOs. We would like to urge Congress to encourage the development of uniform, adequate, and

consistent solvency standards across all types of risk-takers, whether that happens on a State or a Federal basis.

A few words about solvency structures themselves. There is some very complex and interrelated framework in place to regulate solvency on the State level. There are consistent standards to measure and monitor financial performance of risk-taking entities, and they are there to ensure that there is sufficient capital to meet unanticipated needs.

Each of those pieces of the framework, we believe, has a role to play. We would just caution that picking and choosing pieces of that framework, or exempting entities from it, could be risky to the public, without having a full understanding of what the implications are of doing that, because those pieces all fit together into a mosaic for the protection of the public.

The risk that we're really talking about, the risk to the public, comes out of the insuring promise. I believe what we're talking about is having PSOs provide insurance promises directly to the public that are very similar to what an insurance company provides. That is the risk that we believe is similar.

In the work that we have done, we have recognized the portion of the difference in entities between PSOs and regular insurers that we believe is appropriate to recognize, has been recognized in the risk-based capital formula, but we don't believe that there is a difference in that risk level purely based on who owns the entity that's going to be providing those promises to the public.

Also, we believe that without having consistent, uniform standards, there is a danger of some market dislocations and creating some artificial subsidies or dislocations between market segments because of that.

One final point is that, at the beginning of this period of existence of PSOs, we believe is the most important time to be sure that the solvency standards are in place and there to protect the public, because that will be the riskiest time. The period a few years down the road will not be nearly as risky.

I would be glad to answer any questions.

[The prepared statement of William F. Bluhm follows:]

PREPARED STATEMENT OF WILLIAM F. BLUHM, VICE PRESIDENT, HEALTH, AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries appreciates the opportunity to provide comments to the House Commerce Committee Health and Environment Subcommittee on the important issue of appropriate regulation of health insurance entities that assume risk. The Academy hopes that you find these comments helpful as you consider the issue of having provider-sponsored organizations participate in the Medicare program, such as in H.R. 475 and the Administration's 1998 budget proposal.

The actuarial profession is uniquely qualified to examine the various financial risks associated with providing health insurance and health care benefits. Actuaries are experts in evaluating all types of health insurance risk bearing entities' financial status, based on the nature of the insurance risks and the increasing volatility of the U.S. economy. Among other things, actuaries estimate future contingent liabilities. Based on those estimates, they determine whether a health insurance risk bearing entity has adequate surplus and reserves to meet future obligations with sufficient margin.

The Subcommittee on Health and Environment has asked the Academy to discuss solvency regulation; why it is important, the various risks involved with providing health care benefits, and the consequences of inadequate or inappropriate solvency regulation.

The Need for Solvency Regulation

Solvency laws and regulations are primarily in place to protect the public from the consequences of an insolvency. Therefore, the Academy's work has generally assumed that the risk to the public should drive solvency regulation, not the risk to other entities involved with the insurer. In particular, this assumption implies that solvency regulation should not be a function of who owns or controls the risk bearing entity, unless this impacts the financial risk to the public.

At the request of the National Association of Insurance Commissioners (NAIC), these principles were followed when the American Academy of Actuaries Health Organizations Risk-Based Capital Task Force developed recommendations for a health organizations risk-based capital formula. In particular, the NAIC asked the Academy to develop a formula which could apply across all types of licensed health risk takers.

Risk-based capital (RBC) formulas establish benchmark levels of necessary surplus and capital. Under RBC, a minimum surplus level is calculated for each health plan, based on its unique characteristics. The characteristics reflect the health plan's insurance products, assets, provider relationships, reinsurance programs and others. As actual surplus falls below various multiples of this minimum, different regulatory actions are triggered. These standards exist today for life insurance companies and casualty insurance companies through formulas developed by the NAIC, with help of the Academy. There is also a minimum surplus requirement for HMOs which is not risk-based. In addition, the Blue Cross & Blue Shield Association has developed similar standards for their members, and many Commissioners of Insurance have developed formulas for their specific states.

These currently adopted NAIC RBC formulas produce different minimum capital levels for a given block of insurance. This lack of consistency creates different capital standards for organizations providing health coverage, depending on their corporate structure or often even the branch of state government under which they are regulated.

Therefore, one of the primary goals of the Academy for the RBC formula was to establish a consistent RBC measure applicable to the wide variety of organizations that are likely to provide health coverage in the future. The Academy's recommendation to the NAIC included a unified standard for all types of health organizations, intended to be applied to all risk takers.

The NAIC is considering adoption of these standards. Congress should encourage uniform, adequate, and consistent solvency standards for all health insurance risk bearing entities, in order to protect the public. These entities include insurance companies, HMOs, health service corporations (like Blue Cross/Blue Shield plans), physician-hospital organizations, self-insured employers, trusts of various types, and health care providers themselves.

Current Solvency Structure

The goal of a solvency structure under health care reform is to provide a regulatory and industry framework to measure, monitor, and ensure that health insurance risk bearing entities have the financial capacity to provide health care for insureds. There are widely differing solvency structures in place today, depending on the nature of the health plan. For example, a self-insured employer-sponsored health plan is exempt from state insurance regulation by federal law. Such a plan is subject to the financial constraints of federal law only, which are more concerned with avoiding overfunding than underfunding.

Most of the solvency standards applicable to health insurance risk bearing entities today are part of the current state regulatory framework. These standards include: risk-based capital requirements, reserves to absorb fluctuation in asset values and reporting, financial statements based on statutory reporting requirements, licensing requirements, asset investment limitations, the Insurance Regulatory Information System, company examinations by state regulators, minimum contingent reserve and liability standards, premium regulation, capital management polices, and outside rating agencies. Few of these solvency mechanisms currently apply to PSOs. There is also a system of state guarantee associations that serve to protect policyholders when a failure of a covered organization occurs. PSOs are not currently covered under these associations.

As shown by the above list, the current regulatory structure is complex. Each element of the framework is intended to protect against specific perceived risks, and is inter-dependent with other elements of the framework. For example, uniform financial reporting standards are needed to get consistent capital measures, before RBC standards can be applied. Therefore, it is risky to exempt entities from portions of that structure without a full understanding of what the implications are.

It is also important to understand the impact of having different solvency regulation or capital standards for different risk-bearing entities. Different standards will create artificial competitive advantages for certain risk-takers.

The Academy's recommended HORBC formula does reflect a theoretical difference in risk when an individual provider provides services directly. The formula reflects our belief that if an individual provider is taking on the risk, the provider could absorb a certain level of fluctuations in costs, thereby lowering the risk of financial fluctuation. We reiterate, however, that this element of the formula is not a function of who owns the risk-taking organization.

What are the Risks?

Health insurance risk bearing entities either guarantee reimbursement for health benefits or, as in the case of PSOs and some HMOs, guarantee to provide care directly. There are a variety of financial risks connected with these guarantees. These include insurance risks, risks inherent in managed care arrangements, business risks, antiselection risks, regulatory and legal risks, and various investment risks. While each risk does not necessarily occur everywhere, they all exist somewhere. The Academy's monograph number 4, entitled "Actuarial Solvency Issues of Health Plans in the United States" has a detailed discussion on the various risks, who takes them, and tools for managing the risks.

How Managed Care Entities and PSOs Take the Risk

There are many kinds of risk takers in the health care delivery insurance marketplace. This includes providers of benefits, and those who contract with those providers. The providers of benefits include insurance companies, HMOs, health service corporations (like Blue Cross/Blue Shield plans), physician-hospital organizations, self-insured employers, trusts of various types, and health care providers themselves.

Those entities who contract with benefit providers are also at risk. These include the insureds themselves, reinsurers (who are insurers to insurance companies), and health care providers. As the NAIC white paper on risk-bearing entities states, "the ability to provide services does not meaningfully reduce the actuarial risk present in the health care context". This statement is key to understanding the need for appropriate uniform solvency standards for PSOs.

Risk-bearing entities, such as PSOs, assume insurance risk when they market an insurance plan or promise benefits to members. There is a promise to pay for delivering a service which the participant relies on in the same way as insurance. The consequences of non-payment are real to the participant and just as catastrophic as they would be under a similar insurance plan. Since the risk is similar, it seems reasonable that PSOs should be subject to regulation that are the same as an insuring entity making a promise to deliver services and provide benefits.

The Academy's HORBC Task Force allowed for credits where risk is transferred, provided the entity assuming the risk is subject to the same formula.

Considerations on Solvency Regulation Structure

Solvency is best monitored and regulated in the entity that is guaranteeing coverage. In the current environment, this would be at the health insurer level, which is the entity providing the insurance contracts.

Some forms of managed care have had a significant impact on the degree of predictability of costs while others have not. Some examples of managed care which reduce risk include approaches which fix prices (such as negotiated fee schedules), provider risk sharing (such as withholds or bonuses and capitations), and restructure of the cost basis itself (salaries, negotiated budgets). These are recognized in the Academy's recommended HORBC formula.

Conclusion

Under the Administration's 1998 budget plan, PSOs would be allowed to participate in Medicare under minimum federal standards, with states allowed to impose more stringent standards after four years. If Congress is concerned about a level playing field for those participating in Medicare, it will be necessary to ensure that PSOs are subject to similar regulatory and solvency requirements as HMOs and traditional insurers. The Academy is concerned that the proposed minimum solvency standards for PSOs might create undue risk to the public.

We believe there is great need for solvency standards and regulation which depend on risk levels, rather than other factors. These standards should be used to determine whether a health plan can begin operation and continue operation.

The greatest risk to health plan solvency will occur during the initial years of implementation. With this in mind, in order to minimize this risk, the full spectrum of the regulatory structure should be reviewed in light of each element's role in pro-

tecting the public. Appropriate solvency safeguards with adequate oversight and enforcement could greatly reduce the potential for increased insolvency risk.

Mr. BILIRAKIS. Thank you, sir.

Mr. Pomeroy.

STATEMENT OF GLENN POMEROY

Mr. POMEROY. Thank you, Mr. Chairman. Good afternoon, committee members.

My name is Glenn Pomeroy. I am vice president of the National Association of Insurance Commissioners and vice chair of the NAIC's Special Committee on Health Insurance. With me today is David Randall, deputy director of the Ohio Department of Insurance and vice chair of the NAIC's Regulatory Framework Task Force. Together we will be discussing the regulation of provider-sponsored health insuring organizations participating in the Medicare managed care program.

On behalf of the NAIC's Special Committee and its 42 member States, we very much appreciate the opportunity to appear before you today. The NAIC president, Josephine Musser, from Wisconsin, was planning to be here, became ill this morning, and had to return home. She sends her deep regrets.

The States have traditionally regulated the business of insurance, a role affirmed by Congress, in 1945, with the passage of the McCarran-Ferguson Act. We welcome the expressions of Members of Congress in support of the States and urge you not to dilute the States' authority to regulate insurance by treating provider organizations specially in Federal legislation.

We also welcome the support we received today from the NGA and the NCSL. I believe we received a letter from these two sister organizations which indicate that all three organizations speak with one voice on this important topic. Speaking of the States' extensive experience in regulating the business of insurance, we strongly believe that the most appropriate approach to the regulation of health-insuring organizations is by function, not by acronym. We do not view health insuring organizations sponsored by providers as substantially different from other health insuring organizations.

These entities, with varying forms of ownership and affiliations, are required to obtain a State insurance license because of the insurance function they perform. Organizations subject to State insurance regulation already include those sponsored by providers.

A key characteristic of a health insurance arrangement is the spreading of the risk of financial loss among a group of individuals. This spreading of the risk is known as insurance risk. Organizations that assume insurance risk on behalf of an individual employer or other group, such as the Medicare program, are indeed in the business of insurance and should be subject to the consumer protections embodied in State insurance regulation.

Insurance organizations face other forms of risk beyond insurance risk, such as asset risk, interest risk, and general business risk. The regulation of any health insuring organization involves a host of fundamental consumer protections.

Insurance departments license organizations using standards that include financial requirements. Departments also conduct ex-

tensive examinations to review financial condition and market conduct activities. The departments supervise, rehabilitate, and liquidate financially distressed or insolvent organizations.

In addition to the regulation of agents, State insurance departments handle consumer complaints and inquiries. State insurance regulation serves as the foundation for the current regulatory structure governing Medicare managed care, providing a foundation for fundamental consumer protections. To provide these same protections, the Federal Government would need to replicate the States' insurance regulatory framework, resulting in significant and unnecessary cost to the Federal Government.

Why is the regulation of PSOs that serve the Medicare managed care market an important issue? First, many providers lack experience in assuming risk. Second, the elderly and the disabled tend to use more health care resources than others. And third, some providers face complex incentives in today's competitive health care environment. All these factors make effective regulatory oversight an essential component.

There are a number of types of health insuring organizations that are regulated by State insurance departments. These include traditional indemnity carriers, Blue Cross and Blue Shield plans, HMOs, or limited health service organizations. Any of these may be sponsored by providers.

Under the current structure, State standards apply to organizations that perform similar functions, and Medicare does not undercut these requirements. Any Federal proposal that would regulate provider organizations differently from other health insuring organizations first needs to demonstrate that structural differences merit different regulatory treatment.

The States strongly believe that health-insuring organizations that perform similar functions should be subject to similar regulatory standards. Further, insurance regulation by ownership and acronym, as opposed to function, creates an unnecessarily divided regulatory structure and undermines the competitive level playing field that States maintain through sound regulation.

General rules exist to help distinguish between arrangements that have the common elements of an insurance arrangement and those that do not. A common factor among arrangements that generally do not involve insurance risk is that the payment method is linked to the actual delivery of services to an specific enrollee. Consequently, the organization receiving payment does not rely on a pool of enrollees to fund care for specific individuals.

In contrast, health insurance arrangements involve prepayment and are not directly tied to the actual use of specific services by an enrollee. In exchange for a prepayment, a health insuring organization agrees to pay for or deliver a range of services, regardless of the amount of services a consumer actually uses.

Such arrangements are insurance risks for two reasons: First, there is a risk that the services will exceed the amount of the prepayment; and second, the organization pools the prepayments of all covered individuals. Consequently, the health insurance organization relies on the law of averages to ensure that any one individual's use of services will be balanced by the use or lack of use of

other covered individuals. We have a chart that outlines the key common functions of these kinds of arrangements.

Organizations that assume risk through such payment methods as capitation are indeed in the business of insurance and give rise to the public policy concerns that State insurance regulation is designed to address. Most health insurance organizations that are sponsored by providers are licensed as HMOs.

Our formal testimony today includes a description of that licensing process. The average approval time for completed applications for most States is within 90 days. In North Dakota, we recently licensed an HMO sponsored by a major clinic and a hospital. It is regulated under North Dakota's HMO law, just as it should be.

Mr. Chairman, there is another example I wish to cite for you. My predecessor had the unpleasant experience of having to place a large organization that was sponsored by providers into a receivership. Thanks to the State's regulatory authority, the commissioner of insurance was able to act promptly and obtain another source of coverage for the 30,000 people insured by that organization. North Dakota's net worth requirements have since been strengthened to avoid a recurrence of this unfortunate event.

Provider organizations argue that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk rather than insurance risk. That's not the case. As long as pooling of financial risks of loss exists, insurance risk is present, and they are subject to regulation by the States.

In addition, there are a wide range of necessary expenses in delivering health benefits. David Randall of the Ohio Insurance Department can tell us more about the status of recent NAIC and Ohio initiatives that have a similar goal.

Mr. Randall.

Mr. GILLMOR. Mr. Chairman.

Mr. BILIRAKIS. All right. Mr. Randall, you're going to continue on with Mr. Pomeroy's 10 minutes?

Mr. RANDALL. Yes, I am.

Mr. BILIRAKIS. But before you do, I will go ahead and yield to Mr. Gillmor for 30 seconds, because he wanted, in the worst way, to introduce you.

Mr. GILLMOR. I might do it in the worst way, that's right.

I do appreciate this courtesy, Mr. Chairman. I did want to just say a word for Dave Randall, the deputy director of the Ohio Department of Insurance. I have known Dave since I was president of the Ohio Senate and he worked in the Senate. He actually worked as the aide to a State senator who is now one of our colleagues, Bob Ney. I think it's a credit to Dave's wisdom that, when Bob came to Washington, he had the wisdom to stay in Ohio. But he does have a tremendous degree of experience, and I'm sure you will be interested in hearing from him.

Thank you very much, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

Mr. Randall, you may proceed.

Mr. RANDALL. Mr. Chairman and Mr. Gillmor, thank you.

Mr. BILIRAKIS. I can't stop the clock from ticking, but we will give you the time.

Mr. RANDALL. All right. Thank you.

Thank you, Mr. Pomeroy, Mr. Chairman, and members of the committee. To help you understand the rigorous standards we set in the States, our formal testimony today includes a detailed description of the regulatory process for an HMO, from licensing requirements to financial standards, and examinations to market conduct standards.

As you review this material, remember that State insurance insolvency and other standards provide fundamental consumer protections while strengthening the ability of health-insuring arrangements to fulfill their obligation to the consumer and other parties.

State insurance regulators have long recognized that the delivery of health services is evolving away from traditional fee-for-service arrangements. Today, managed care arrangements abound. Through the NAIC, the member States are seeking to promote a more competitive marketplace by ensuring that regulation occurs on a level playing field. We are doing this through an initiative called CLEAR, the Consolidated Licensure of Entities Assuming Risk. Through the NAIC, States are addressing the changes which are taking place in the health insurance market.

To facilitate the CLEAR initiative, our task force is in the midst of a thorough review of NAIC model laws, which include the financial standards and reporting requirements, as well as health plan accountability standards. These accountability standards relate to network adequacy, quality, grievances, utilization review, provider credentialing verification, and confidentiality. Issues related to data reporting and consumer disclosure are also being explored.

As Commissioner Pomeroy pointed out, the CLEAR initiative seeks to promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. CLEAR also serves to clarify that the wide array of organizations performing managed care functions fall within the scope of State regulation, whether they be HMOs, PPOs, point-of-service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial plans, or any other health plans which finance and deliver health care.

Ohio has been one of the States reviewing their health insurance statutes with the objective of developing a comprehensive licensure structure. The Ohio Insurance Department, with the assistance of a dedicated team of professionals, has been contemplating for several years a regulatory structure that defines the business of insurance for managed care entities by focusing on how they function and not merely on how they are structured.

Our department recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. Currently under consideration by the Ohio General Assembly, the proposed act repeals laws which govern prepaid dental health plan organizations, medical care corporations, health care corporations, dental care corporations, and HMOs. In their place, the Ohio proposal creates one type of regulated entity called a "health insuring corporation," or HIC. The HIC is defined broadly, to encompass all entities that assume insurance risk.

Further licensure standards are an important component of this proposal. Why is licensure so important? Minimum licensing standards help ensure that funds will be available to pay consumer

claims. Such standards also provide a level of security that a provider will possess the financial ability to make good on their obligations to the consumer. Further, minimum licensing standards allow the organization and regulators sufficient time to take corrective action should the organization's financial condition be in jeopardy.

At the NAIC, an important component of the CLEAR effort is the development of a health organizations risk-based capital formula, which Mr. Bluhm mentioned earlier. The RBC approach is a formula that sets minimum capital requirements according to the level of known risk being assumed by the HIC. Such a formula acknowledges arrangements that increase and reduce risk. It is a marked departure from the traditional fixed level approach that States have used to establish insurers' minimum capital and surplus.

We at the NAIC are now developing a prototype health RBC formula for managed care organizations. This process of development, like NAIC models, is an open process where we seek the input and comment of interested parties. We are fortunate to have input from consumers, trade associations, academics, and health care economists.

As your committee and other Members of Congress deliberate this issue, and in particular the regulation of PSOs, we urge you to recognize the States' success in developing a regulatory framework.

I know that Commissioner Pomeroy would now like to conclude with some other issues.

Mr. BILIRAKIS. If you can please summarize.

Mr. POMEROY. If I could just conclude by saying, Mr. Chairman, thank you again for letting us be here. The National Association of Insurance Commissioners, the National Governors Association, the National Conference of State Legislators all agree with comments you made in your opening remarks, Mr. Chairman. Medicare beneficiaries should not bear the ultimate risk in these kinds of arrangements.

We feel that Federal preemption of State insurance regulation will weaken protections for Medicare beneficiaries, and we appreciate the opportunity to provide you with these concerns.

[The prepared statement of David Randall and Josephine Musser follows:]

PREPARED STATEMENT OF JOSEPHINE MUSSER, PRESIDENT, NAIC

INTRODUCTION

Good Morning Mr. Chairman and Members of the Subcommittee. My name is Josephine Musser. I am President of the National Association of Insurance Commissioners (NAIC) and Chair of the NAIC's (EX) Special Committee on Health Insurance. I am also Commissioner of Insurance for the State of Wisconsin. With me is David Randall, Deputy Director of the Ohio Department of Insurance and Vice Chair of the NAIC's Regulatory Framework Task Force. Together we are going to speak to you today about the regulation of provider-sponsored health insuring organizations participating in the Medicare managed care program.

The NAIC, founded in 1871, is the nation's oldest association of state public officials and is composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. The NAIC's (EX) Special Committee on Health Insurance is composed of 42 of our members. The NAIC established this Special Committee over three years ago as a forum to discuss federal proposals related to health insurance reform and to provide technical advice on a nonpartisan basis

to all who sought our expertise. On behalf of the NAIC Committee, we would like to thank you for the opportunity to discuss with you issues related to the regulation of health insuring organizations sponsored by providers.

The states have traditionally regulated the business of insurance. This traditional role was affirmed by Congress in 1945 when Congress passed the McCarran-Ferguson Act.[1] We believe that all health insuring organizations, whether they are sponsored by providers or others, ought to continue to be regulated by the states. States welcome the expressions by members of Congress in support of the states. In the case of insurance regulation, we urge Congress not to dilute the states' authority to regulate insurance by treating provider organizations specially in federal legislation.

We would like to state at the outset that, based on our experience in state insurance regulation, we do not view health insuring organizations sponsored by providers as substantively different from other health insuring organizations. Health insuring organizations, with varying forms of ownership and affiliations, are licensed by the several states. These organizations are required to obtain a state insurance license because of the insurance function they perform. Organizations subject to state insurance regulation include organizations that are sponsored by providers. The NAIC Committee submits that any federal proposal that would regulate provider organizations differently from other health insuring organizations first needs to demonstrate that structural differences merit different regulatory treatment. We do not believe that any such showing has been made.

Health insuring organizations contract with individuals, employers, or other groups to receive a prepayment in exchange for covering the cost of an unknown, future level of health care services. In doing so, the health insuring organization assumes what is commonly known as insurance or *actuarial risk*. Under this arrangement, the individual, employer, or other group transfers to the health insuring organization some or all of their own risk of financial loss as a result of the use of health care services. Because the actual level of services that will be used is unknown, the health insuring organization is at risk for financial loss if the amount of services used exceeds the amount of the prepayment (commonly known as a premium). The principal characteristic of a health insurance arrangement is not only the transfer of the risk of financial loss to the health insuring organization. The health insuring organization also spreads the risk of financial losses associated with the use of health care services by any one individual among a group of individuals insured by the organization. Organizations that assume insurance risk on behalf of an individual, employer, or other groups, such as the Medicare program, are engaged in the business of insurance and should be subject to state insurance regulation.

In addition to insurance risk, all health insuring organizations must deal with several other forms of risk, including asset risk and general business risk. All health insuring organizations face asset risk; the risk that existing assets will decline in value and erode surplus as a result of that decline. Additionally, all health insuring organizations face general business risks; the range of risks associated with any other type of business such as assessments, administrative expense overruns, and environmental changes. To a large extent, the different risks health insuring organizations face are interrelated. For example, losses associated with insurance risk affect the ability of a health insuring organization to meet the many demands associated with general business risk.

Examples of Principal Types of Risk for Health Insuring Organizations:

- Insurance or Actuarial Risk
- Asset Risk
- General Business Risk

State insurance departments regulate health insuring organizations through a host of fundamental consumer protection activities. Insurance departments license organizations engaged in the business of insurance. The licensing standards include financial requirements that the organization must meet. The departments conduct extensive examinations of licensed organizations to review their financial condition and market conduct activities. State insurance departments supervise, rehabilitate, or liquidate financially distressed or insolvent organizations. Also of importance, state insurance departments handle complaints and inquiries from the general public. The departments also regulate agents and others that serve insurance organizations.

Health maintenance organizations (HMOs) and competitive medical plans (CMPs) participating in the Medicare managed care program must comply with state licensure standards in addition to federal standards. The federal standards build upon,

[1] 15 U.S.C. § 1011-1015.

rather than preempt, fundamental state requirements. Importantly, all health insuring organizations serving the Medicare managed care program are regulated in a consistent, level fashion. State insurance regulation serves as the foundation for the current regulatory structure. It provides fundamental protections that extend beyond financial solvency and other licensing standards to market conduct standards as well as financial examination activities. These fundamental consumer protections are essential because of the public policy concerns inherent in the health insurance function. To provide these consumer protections itself, the federal government would need to replicate the states' insurance regulatory framework. Doing so would result in significant and unnecessary costs to the federal government.

The appropriate manner of regulating provider-sponsored health insuring organizations that serve the Medicare managed care program is an important question for several reasons. First, many providers lack experience in assuming insurance risk. Second, the population served by the Medicare program, the elderly and disabled, tend to use more health care resources than other individuals. And third, some providers face complex incentives in today's competitive health care environment. For example, hospitals face added pressures in a managed care market. They have to balance the challenge of managing care cost-efficiently with the challenge of filling their beds and increasing hospital market share.[2] These challenges may make it more difficult for them to operate within the limited payment available under an insurance arrangement. Each of these factors argue for effective regulatory oversight.

Organizations that are sponsored by providers participate and make important contributions to the health insurance market. However, states believe strongly that all health insuring organizations that perform similar functions should be subject to similar regulatory standards. States have developed their regulatory standards through long-standing experience. Particularly in today's intensely competitive health insurance environment, where the risk and magnitude of insolvency can be significant, states are a necessary component to any regulatory structure for health insuring organizations participating in a federal program.

CHARACTERISTICS OF HEALTH INSURING ORGANIZATIONS

Types of Health Insuring Organizations

In the health insurance context, there are a number of types of health insuring organizations that are regulated by state insurance departments. This section reviews the types of health insuring organizations regulated by the states and the insurance functions they perform.

State-regulated health insuring organizations include: traditional indemnity insurance carriers; Blue Cross and Blue Shield plans; health maintenance organizations; and, limited health service organizations.

Under a traditional indemnity insurance contract, the health insuring organization takes on the risk of loss associated with a medical condition. The risk is assumed in exchange for a prepayment by an individual, employer, or other group. Through this indemnity contract, the insurer may promise to pay an individual who has already paid for the medical care received; this is the traditional approach for indemnity insurance carriers. Or, the insurer may promise to pay the provider for medical care received by the subscriber; this is the traditional approach for Blue Cross and Blue Shield plans. In other words, the traditional indemnity insurance carrier and the traditional Blue Cross and Blue Shield plan pays the individual or the provider for the medical services that are received. The traditional indemnity insurance carrier or traditional Blue Cross and Blue Shield plan does not actually deliver, or contract for the delivery of, those medical services.

Health maintenance organizations (HMOs) are health insuring organizations that manage care and serve both an insurance and delivery function. HMOs may be free-standing or subsidiaries of an indemnity insurance carrier or Blue Cross and Blue Shield plan. In consideration for a prepayment by an individual, employer, or other group, HMOs deliver or arrange for the delivery of health care services. Like the traditional indemnity insurer and traditional Blue Cross and Blue Shield plan, the HMO is responsible for the cost of care. HMOs differ from traditional indemnity insurance carriers and traditional Blue Cross and Blue Shield plans in that HMOs are responsible for delivering or arranging for the delivery of that care as well. HMOs fulfill this responsibility by entering into contractual arrangements with providers or groups of providers, by providing the services directly themselves, or through some combination thereof. For example, if an individual is in need of a ton-

[2] Sutton, Harry L., Jr. , F.S.A., Reinsurance in the Managed Care Environment, Society of Actuaries (1996).

sillectomy, the HMO is not only responsible for covering the cost of the physician, hospital, and other services related to the tonsillectomy, but is also responsible for maintaining a network of available physicians, hospitals, and other health care resources to deliver the tonsillectomy.

Traditional indemnity insurance carriers may also offer services that do not involve insurance risk. These lines of businesses may include third party administrator services (TPA) or preferred provider organizations (PPOs) that do not bear insurance risk. In other words, under these arrangements, the health insuring organization is not spreading the financial risk of loss among a group of persons. Instead, it basically accepts a fee to perform administrative services, such as claims processing and marketing. Some HMOs also offer non-insurance risk TPA and PPO-type services where the HMOs "rent" the networks that they created and the renters of the network pay for health care services on a fee-for-service basis.

Limited Health Service Organizations (LHSOs) are organizations that deliver or arrange for the delivery of a limited range of health services on a prepaid basis. Examples of limited health services are dental care services, vision care services, mental health services, and pharmaceutical services.

An organization that is one of these types of health insuring organization " traditional indemnity insurance carrier, Blue Cross and Blue Shield plan, HMO, or LHSO " may or may not be sponsored by providers. As described in more detail later in this testimony, there are HMOs licensed in the states, including Wisconsin and Ohio, that are owned or controlled by providers. Under the current structure, state standards apply to organizations that perform similar functions and Medicare requirements do not undercut these requirements. Insurance regulation by ownership and acronym as opposed to by function would create an unnecessarily divided regulatory structure and severely undermine the ability to foster a competitive level playing field in the health insurance market. Further, we submit that such a split structure erodes the efficacy of state regulation of health insuring organizations.

Common Elements of Health Insuring Organizations

The activities of all health insuring organizations share the common elements of the insurance function. The extent to which an entity is provider-sponsored does not impact the analysis regarding their function (and hence, the regulatory structure to which they should be subject). Consequently, the most appropriate approach to the regulation of health insuring organizations is by function and not by acronym. This section reviews the common elements of the arrangements entered into by health insuring organizations and distinguishes these arrangements from those which generally do not involve insurance.

Whether they are provider-sponsored or not, health insuring organizations " traditional indemnity insurers, Blue Cross and Blue Shield plans, HMOs, or LHSOs " have certain key elements in common. Health insuring organizations contract with an individual, employer, or other group. The purpose of the contract is to cover payment for a range of health care services which may be required in the future. The amount of the services that will actually be utilized is unknown. Health insuring organizations accept a prepayment from the individual, employer, or other group in exchange for assuming the financial risk associated with the cost of the health care services covered by the contract. Health insuring organizations pool all of the prepayments by the individual, employer, or other group of persons to cover the cost of health care services used. Health insuring organizations are at risk for financial loss if the cost of an individual's care is greater than anticipated and exceeds the prepayment made by or on behalf of the individual. All health insuring organizations are involved in arrangements that contain these elements.

Common Elements of Health Insuring Organizations

- Contracts with an individual, employer, or other group
- Pays for or delivers a range of health care services
- Pays for or delivers an amount of services that is unknown in advance
- Accepts a prepayment for assuming the financial risk associated with health care services
- Spreads the risk of loss among a group of persons by pooling the prepayments made by or on behalf of individual enrollees to cover the cost of services for all individuals in the group
- Runs the risk of suffering financial loss if the cost of an individual's care is greater than anticipated.

General rules exist to help distinguish between arrangements that have the common elements of an insurance arrangement and those that do not. A common factor among arrangements that generally do not involve insurance risk is that the payment method is linked to the actual use of predetermined and identifiable services to a specific enrollee. Consequently, the organization receiving the payment does not

rely on payments for a pool of enrollees to fund care for specific individuals. The payment of a fee that is received to perform a specific service is a factor that distinguishes an insurance arrangement from one that is not an insurance risk arrangement. No payment is received for services which are not used.

In contrast, health insurance arrangements are not directly tied to the actual use of specific services by an enrollee. In exchange for a prepayment, the health insuring organization agrees to pay for or deliver a range of services, regardless of the amount of services the enrollee actually uses. The health insuring organization is liable for expenses beyond the prepaid amount. If the enrollee uses fewer services than are covered by the prepayment, the health insuring organization keeps the remaining amount of the payment.

An arrangement involving a prepayment that is not tied directly to the actual use of specific services is insurance risk for two reasons. First, the health insuring organization bears the risk that the costs of any individual's use of services will exceed the amount of prepayment by that individual. Second, the health insuring organization pools the prepayments of all covered individuals. Consequently, the health insuring organization relies on the law of averages to ensure that any one individual's use of services will be balanced by the use (or lack of use) of other covered individuals.

Organizations that assume insurance risk through the receipt of a prepayment for an undetermined amount of services are engaged in the business of insurance and give rise to the public policy concerns that insurance regulation is designed to address. Arrangements that involve the spreading of risk often rely upon complex, actuarial analysis involving the calculation of statistical risk for their financial success. In contrast, business risk arrangements, like those that involve the payment of a fee for a specific service, do not involve risk-spreading and do not inherently carry with them the same nature of risk as insurance risk. Additionally, prepayment for the future delivery of services in an insurance risk arrangement establishes a long-term commitment to the consumer. State insurance solvency and other standards provide fundamental protections to consumers against financial incentives inherent in health insurance arrangements. State standards also serve to strengthen the ability of participants in the health insurance market to fulfill their obligations to the consumer and other parties affected by the health insurance arrangement.

Provider organizations have argued that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk rather than insurance risk. That is not the case. As long as pooling of financial risks of loss exists, insurance risk is present and they are subject to regulation by the states. Direct provision of services by providers will rarely reduce the insurance risk to a *de minimis* level. Many question the assertion that providers are willing to take reductions in their own salaries if the organization experiences significant losses. Nevertheless, even if providers are willing to work on greatly reduced or nonexistent additional income, the health insuring organization still may be responsible for a wide range of expenses necessary to support the provision of health care services. In addition to the expenses of physician services, examples of additional expenses may include:

- Other Clinical Personnel (including nurses, nurse assistants, physical therapists, laboratory technicians, etc.)
- Administrative Staff (including business office managers, registration clerks, secretaries, etc.)
- General Administrative Expenses (including medical and paper supplies, patient registration, information systems, data and claims processing, etc.)
- General Facility Expenses (including electricity, lights, water, phone, etc.)
- Laboratory services
- Debt Service (including for facility, equipment, etc.)
- Other Business Expenses (including legal and actuarial services, etc.)

Further, health insuring organizations must deal with the general business risks associated with having adequate cash flow (commonly known as liquidity). This is a particularly important issue for organizations that are owned or controlled by providers. These organizations, which may be nonprofit, may have inconsistent levels of cash flow available to meet expenses. Many of their assets are in buildings and equipment, which are unavailable if the organization needs additional funds to pay claims or cover general business expenses.

The ownership or control of the health insuring organization does not affect the type or magnitude of risk in an arrangement to any substantive degree. The type of risk being assumed by these organizations triggers the need for the application of fundamental state consumer protections. All organizations that perform the same

or similar function, irrespective of the organization's acronym, should be subject to the same or similar standards when serving the Medicare program.

State Regulation of Health Insuring Organizations

Because of the public policy concerns present when an organization is engaged in the business of health insurance, health insuring organizations need careful oversight. States have developed significant expertise in providing this oversight as the primary regulators of insurance, which was underscored by Congress in the McCarran-Ferguson Act. The most fundamental components of state regulation include the licensing process, financial standards and examinations as well as market conduct standards and examinations. The process for the licensing of a health insuring organization is a detailed process in Wisconsin, as it is in the other states. State regulation of HMOs can be used as an example to illustrate the states' regulatory process for health insuring organizations.

The regulation of HMOs is an apt example of the state regulatory process because most health insuring organizations currently operating in the marketplace that are sponsored by providers are licensed as HMOs. In Wisconsin, for example, most of the HMOs operating in Wisconsin were originally organized by sponsoring provider groups. The ownership status of these organizations has changed over time as the marketplace has consolidated. Wisconsin currently has sixteen (16) licensed HMOs that are provider-owned or controlled and two (2) indemnity insurers that are provider-owned or controlled.

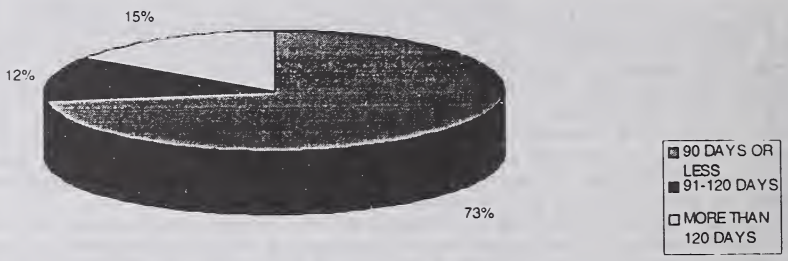
A few examples may provide a sense of the various forms and structures of these provider-sponsored health insuring organizations. In Wisconsin, one of the licensed health insuring organizations is sponsored by a hospital and a clinic. Another licensed organization is wholly owned by an integrated delivery system. Yet another organization is owned one-third by an indemnity insurer, one-third by a hospital, and one-third by a clinic.

Licensing—The first step in the regulatory process for an HMO is to submit to the state an application for a license (also called a certificate of authority). Organizations that perform the functions of an HMO without obtaining a license are subject to Wisconsin's unauthorized insurer statute. The application includes a variety of important materials such as the organization's articles of incorporation, bylaws, proposed detailed business plan, feasibility study, financial statements, and commitment of a viable provider network. The applicant must also meet minimum start-up capital requirements. Several staff members are usually necessary to review properly each individual application.

Once an application is received, the state will review the application to determine if all the information needed to perform a proper review is included. The state will also verify the information contained in the application. For example, the state will want to make certain that there is sufficient capital and surplus deposited in an acceptable financial institution.

In Wisconsin, the average application processing time is approximately 60 days. This number varies by state. The length of the application processing time is dependent upon a number of factors including the length of time it takes for an application to become complete, the number of applications under consideration at a particular time, and the number of staff available to review the applications. Usually, the initial submission of the application is incomplete. The average application processing time for complete applications by most states is within ninety (90) days. For reference, the appendix of this testimony includes a list of state insurance department contacts for questions on individual state application processes. This list of state insurance department health contact persons can also be found on the NAIC's home page on the internet.

AVERAGE LENGTH OF COMPLETE HMO APPLICATION PROCESSING TIME
PERCENT SURVEY RESPONDENTS
N=26



Source: NAIC State Insurance Department Survey, February 1997.

The completeness of the application and the responsiveness of the applicant can greatly affect the length of the application process. The states have found that applicants who familiarize themselves with the application process prior to filling out an application receive final responses to their licenses more quickly. State insurance departments recommend to applicants that they meet with the department prior to filling out an application to learn more about the application process, including the components of a successful application and the pitfalls to avoid. Departments also recommend that applicants maintain contact with the department while developing the application. Organizations that follow this approach tend to submit applications that are closer to completion, and consequently, tend to have applications that can be processed more quickly. Extended periods of time for application processing are often the result of inadequate information from the applicant or lack of timely response to department requests for information.

Financial Standards and Examinations—Every state regulates HMOs as does the District of Columbia, American Samoa, and Puerto Rico. More than half of the states have HMO laws based upon the NAIC's Health Maintenance Organization Model Act (the "HMO model"). The HMO model governs persons that deliver or arrange for the delivery of basic health care services to enrollees on a prepaid basis. Under the HMO model, HMOs are subject to initial minimum net worth requirements of $1,500,000 and must maintain minimum net worth requirements of $1,000,000.[3] Contracts between the HMO and a contracting provider must contain a hold harmless provision that prevents the provider from holding the subscriber or enrollee liable if the HMO does not pay the provider.

In Wisconsin, the initial minimum net worth requirements are $1.125 million. This $1.125 million must consist of $750,000 of capital and $375,000 of initial surplus. The capital requirements must be met through cash contributions by the HMO's sponsors and stockholders and not through such mechanisms as lines of credit, letters of credit, or subscription agreements.

HMOs must also maintain financial solvency and stability for the protection of HMO enrollees and the health insurance market. Wisconsin HMOs must maintain a minimum net worth of $750,000 or three (3) percent of the previous twelve (12) months' premium, whichever is greater. They must also maintain a security deposit equal to one (1) percent of the premium written by the HMO in the prior year. Further, as with any other insurance company doing business in Wisconsin, the HMO must undergo an annual CPA audit. Typical reinsurance practices for Wisconsin HMOs are to maintain $50,000 to $75,000 in reinsurance coverage. The Wisconsin Office of the Commissioner of Insurance examines the business plan submitted by the HMO to assess its approach and ensure that it is prudent.

In addition to the financial standards that a health insuring organization must meet, states perform financial examinations of health insuring organizations; this is one of the most important aspects of state insurance regulation. These financial

[3] Specifically, the model requires that HMOs maintain a minimum net worth equal to the *greater* of $1,000,000; or two percent of annual premium revenues on the first $150,000,000 of premium and one percent of annual premium revenues in excess of $150,000,000; or an amount equal to the sum of three months uncovered health care expenditures; or an amount equal to the sum of eight percent of annual health care expenditures (except those paid on a capitated basis or managed hospital payment basis) and four percent of annual hospital expenditures paid on a managed hospital payment basis. NAIC Model Act Section 13 (model 430).

examinations involve becoming familiar with the company's management and operations, holding meetings with the organization, and reviewing the books and records of the organization. The examination will include a review of audit operations and controls, budgeting and budget monitoring processes, and financial planning and reporting processes. Certain aspects of the organization may be targeted by the state based upon the research leading up to the actual examination or the course of the examination itself. If there are indications of financial problems, the examination will be more comprehensive than otherwise.

One of the most important aspects of state regulation is the ability of the state to intervene in the event of financial problems. When the state becomes aware of a financial problem, it will conduct either informal or formal supervision activities which might include requesting a business plan for resolving problems or requiring a change in certain business practices to correct the problems. The state may also place the organization under its supervision until such time as the organization can perform appropriately the necessary functions without supervision. If all else fails, the state may liquidate the organization.

Market Conduct Standards and Examinations—Further, the states establish market conduct standards which they monitor and enforce. Market conduct standards related, but not limited to, marketing, the issuing of policies, and claims handling must be met. For health insuring organizations, such as HMOs, standards related to quality assurance, grievance, provider credentialing, and other areas are also relevant.

States perform market conduct examinations to determine compliance with state market conduct standards. In a market conduct examination, the state insurance department initiates and conducts an extensive examination of a health insuring organization, including visits to the organization's offices, to determine how the company is conducting its business within the state. These examinations focus on such areas as an organization's marketing and sales, and its payment of claims and involve the review of numerous records and files.

According to one source, approximately 15-20 percent of the existing HMOs in this country are estimated to be organizations sponsored by providers.[4] A recent NAIC survey of state insurance departments indicates that, of the 39 states which have responded to the survey thus far, at least 27 of them currently have licensed organizations that are owned or controlled by providers under their insurance laws. A number of states have applications pending or are in discussions with organizations that are owned or controlled by providers and that plan to file an application with the department. And, as will be discussed below some states have organizations that were owned or controlled by providers upon initial licensure but have experienced change in ownership or control since that time.

The vast majority of these organizations are licensed as HMOs. One example of a licensed HMO owned by providers in Ohio is U.S. Health HMO. U.S. Health HMO was formed by an organization composed of U.S. Health Corporation, a hospital-owned entity, and Medical Group of Ohio, an independent practice association. The premium paid to U.S. Health HMO, an entity recently licensed by the Ohio Department of Insurance, is distributed to pay administrative and marketing expenses, contracting providers, and profits to the provider owners.

The state of Texas reports that about one-half of the HMO licenses issued in the past two years have been to organizations sponsored by providers. Some examples of these organizations are hospital organizations such as, Texas Children's Hospital, Memorial Sisters of Charity, and Seton Health Systems, as well as physician organizations such as, Physicians Care HMO. In the state of Pennsylvania, several HMOs owned or controlled by providers serve both the urban and rural markets. One of these organizations, Geisinger Health Plan in Pennsylvania, which is currently composed of a medical center and physician group practice, is said to be the largest rural HMO in the country.

Several states, including some that currently do not have licensed organizations that are owned or controlled by providers, reported that some licensed organizations may have been initially formed by providers but are no longer owned or controlled by providers due to mergers or management changes. Changes in ownership of an organization are not that unusual given the evolution and rapid consolidation in today's health insurance marketplace.

Even those few states that have developed provider-specific laws mostly have established standards that are similar or almost identical to the state's HMO laws. The states that have done so include Georgia, Iowa, Kentucky, New York, Okla-

[4] Pat J. Butler, J.D., Dr. P.H. and Elizabeth Mitchell, *Health Care Provider Networks: Regulatory Issues for State Policy Makers,* National Academy for State Health Policy (February 1996) citing Physician Payment Review Commission *1995 Annual Report to Congress.*

homa, and Texas. Where there are differences in regulation between provider-specific and non-provider-specific laws, some states tend to be leaning toward eradicating those differences. For example, the Health Systems and Plans Committee of the state of Iowa's Health Regulation Task Force recommended that differences between the provider-specific and non-provider-specific laws be eliminated. A very few states have indicated that they may not regulate health insurance organizations that assume risk under certain limited circumstances.

Consolidated Licensure Initiatives

Consistent regulatory standards according to the function of the health insuring organization rather than according to the acronym by which it is often known is the most appropriate approach to health insurance regulation in today's health insurance market. Interest in becoming a health insuring organization in the managed care market is certainly not limited to providers. Most, if not all, health insuring organizations are eager to gain a significant presence as a provider of managed care services in any given market. State insurance regulators recognize that the delivery of health services is evolving away from traditional fee-for-service insurance arrangements to managed care arrangements of many types. Through the NAIC, states are addressing the changes which are taking place in the health insurance market. The NAIC's Regulatory Framework (B) Task Force has begun a review of NAIC model laws as part of NAIC's Consolidated Licensure of Entities Assuming Risk (CLEAR) initiative.

Through this initiative, the members of the NAIC seek to promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. CLEAR also serves to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial plans, and any other plans which finance and deliver health care, fall within the scope of state regulation. The NAIC's CLEAR process will include a review of financial standards and reporting requirements as well as the incorporation of health plan accountability standards. These standards, almost all of which are completed relate to: network adequacy, quality, grievance, utilization review, provider credentialing verification, and confidentiality. Issues related to data reporting and consumer disclosure are also being explored.

Some states are reviewing their health insurance statutes with the objective of developing a comprehensive licensure scheme. The Ohio Insurance Department has been contemplating for several years a regulatory structure that defines the business of insurance for managed care entities by focusing on how they function and not merely on how they are structured. It recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. The bill repeals the laws which govern prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations, and creates one type of regulated entity called health insuring corporations (HICs). The HIC is defined broadly enough to encompass all entities that assume insurance risk. This legislation has been sponsored by State Representative Dale VanVyven and State Senator Karen Gillmor and is currently pending in the Ohio General Assembly.

Under its uniform licensure bill, all managed care plans conducting the business of insurance would be subject to minimum financial standards. The Department feels that is appropriate for the following reasons: Minimum standards help to ensure that funds will be available to pay consumer claims; Minimum standards provide purchasers of insurance with a level of security that health insuring organizations will possess the financial ability to make good on their obligations as stated in the policy or contract; and, Minimum standards allow health insuring organizations, and if necessary, regulators the time to take corrective action should the organization's financial condition become impaired.

At the NAIC, an important component of the CLEAR effort is the development of a Health Organizations Risk-Based Capital (HORBC) formula. The risk-based capital (RBC) approach is a formula that sets minimum capital requirements according to the level of known risk being assumed by the health insuring organization. An RBC formula acknowledges arrangements that increase and reduce risk, such as the extent to which services are directly delivered or risk is shifted through payments to subcontracting providers. An RBC formula is a marked departure from the traditional fixed level approach that states have used to establish insurer's minimum capital and surplus requirements. RBC formulas have been in use for several years in state regulation of life and health, and property and casualty, insurers.

The NAIC HORBC Working Group is now developing a prototype health RBC formula for managed care organizations. In addition to testing, debating, and reviewing the formula proposed by the American Academy of Actuaries (which provided technical assistance to the NAIC), the NAIC is also soliciting input from interested parties, trade associations (including those that represent providers), academics and health care economists. The input from all interested parties is being used by the NAIC HORBC Working Group to develop the prototype formula as a practical regulatory tool. The working group anticipates the prototype formula will be completed this summer. As with the life and health, and property and casualty, formulas, the NAIC's HORBC formula for managed care organizations will be reassessed and refined continuously to reflect the results of ongoing evaluation and new arrangements that have developed in the marketplace.

The NAIC's CLEAR effort, as exemplified by the objectives of the Ohio bill, embodies the states' focus on regulation by function and not by acronym. All health insuring organizations engage in functions that involve a range of risks. State insurance regulation provides fundamental consumer protections for consumers and others that may be affected by the health insurance arrangement. The ownership or control of the organization does not alter to any substantive degree the extent to which that risk is present or those fundamental consumer protections are essential.

STATE INSURANCE REGULATION AND THE MEDICARE PROGRAM

State insurance regulation complements well the objectives of the Medicare program for a number of reasons. The state regulatory framework reassures the federal government that the organizations with which it contracts have met fundamental standards for engaging in insurance arrangements. It also assures the federal government that these organizations are receiving an adequate level of oversight for those functions. These fundamental standards are not limited to financial solvency standards. State insurance regulations related to market conduct standards and financial examination activities are also essential components for effective consumer protection. Because of the activities of the states, the federal government saves considerable resources which it would otherwise have to spend in order to regulate effectively health insuring organizations.

Preemption of State Insurance Regulation

Under the current regulatory framework for Medicare, an HMO or competitive medical plan is required to obtain a state insurance license prior to serving Medicare managed care beneficiaries as a Medicare risk contractor. In most instances, the Medicare HMO is also required to serve commercial enrollees as well. However, in the 104th and 105th Congress, proposals have surfaced which would remove some of the state regulatory foundation for these plans. For example, under H.R. 475, the "Provider Sponsored Organization Act of 1997," health insuring organizations that meet the definition of "qualified provider-sponsored organization" (PSO) would not be required to meet either of these requirements in certain circumstances.

H.R. 475 defines "qualified provider-sponsored organization" as a public or private entity that is a provider or a group of affiliated providers organized to deliver a spectrum of health care services (including basic hospital and physicians services) under contract to purchasers of such services. It does list four ways in which an organization would be considered a group of affiliated providers. The specific language of H.R. 475 makes it difficult to understand what organizations actually would be considered a qualified PSO. The bill does not define the term provider. The definition of affiliation is also loose. Further, while qualified PSOs must provide a substantial portion of services directly, the definition of substantial portion is left to be defined by the Secretary.

The definition of qualified PSO in this bill has the same problems as other federal proposals that have attempted to differentiate a provider-sponsored health insuring organization from one that is not provider-sponsored. Health insuring organizations currently licensed by the states as HMOs are not mutually exclusive from the organizations that might fall within the proposed legislation's definition of qualified PSO. Because of the lack of substantive difference among provider and non-provider health insuring organizations, the proposed definitions for PSOs cannot help but sweep in non-provider groups. Favored treatment by acronym for organizations that are not substantively different from other health insuring organizations will result in more fragmentation of the health insurance market and undermine the state regulatory process. Further, we respectfully submit that the decision of what is an organization qualified to participate in the health insurance market, whether public or private, ought to remain with the states.

The bill recognizes that these organizations are involved in health insurance activities, and would otherwise be subject to state insurance laws by requiring that they obtain a state insurance license after January 1, 2002. Yet, the bill also establishes federal standards for these organizations, including solvency standards. Until January 1, 2002, the state may not license health insuring organizations that only provide health insurance services to the Medicare managed care program and are qualified PSOs. The bill gives the Secretary of the Department of Health and Human Services (HHS) ninety (90) days to process an application for certification as a qualified PSO after receipt of a completed application. This timeframe may be significantly less than the timeframe the Secretary currently takes to process the application of a Medicare risk contractor. According to one source, it takes approximately six (6) months to obtain approval as a Medicare risk plan once a complete application has been submitted.[5]

The bill ties the states' ability to perform its responsibilities after January 1, 2002 to the adoption of specific federal requirements shifting significant responsibility away from the states. After January 1, 2002, a state may license these organizations if the state's solvency standards are identical to the federal standards and its other standards are substantially equivalent to federal standards. Further, the bill gives the Secretary of HHS the authority to waive state licensure requirements if the state does not act on the application within 90 days, or the state denies the application and the Secretary determines that the state's standards impose unreasonable barriers to market entry. The bill also requires that the Secretary of HHS contract with the appropriate state agency to monitor the qualified PSO's performance.

While the bill draws upon the NAIC's HMO model for solvency requirements, its differences from the model are significant. These differences include the requirements for minimum net worth, the factors that are required to be considered in the calculation of net worth requirements, and the statutory accounting treatment of health delivery assets. The adoption of these standards at the federal level will undermine effective solvency regulation at both the state and federal level.

In addition to providing for inadequate solvency standards, the bill also does not consider the differences in health insurance markets throughout the country. States have experienced different levels of managed care penetration, in part because of the different evolutionary stages of their health care markets. The level of managed care penetration impacts the kinds of standards that might be appropriate. Consequently, uniform regulatory standards across the country may hinder, instead of foster, the growth of managed care in the Medicare program or the commercial market. We respectfully request that this Subcommittee acknowledge the differences in heath insurance markets and recognize the expertise of the states in applying appropriate consumer protection standards for their jurisdictions.

Because, under this proposal, the states will not have the ability to perform basic underlying licensure activities, for the next few years the federal government will be exclusively responsible for enforcement of the bill's standards. Without the underlying licensure activities conducted by state insurance departments, the federal program will be burdened with an additional degree of monitoring and enforcement for these organizations. This burden may be particularly acute given the lack of experience of many providers in assuming insurance risk. The early years of a health insuring organization's development are the most critical and precarious. While the Medicare program has in place some standards and performs some oversight, the level of standards and oversight do not mirror the depth of state regulation.

Further, the Medicare program does not currently have in place the resources to duplicate the state regulatory framework or the breadth of experience to perform effective consumer protection. Absent significant investments in a regulatory framework by the federal government, consumers will not benefit from the necessary protections offered by state insurance regulation.

CONCLUSION

For state insurance regulators, the determination of whether and how to regulate an organization is triggered by the function the organization performs and not the acronym by which the organization may be known. In making such assessments, state insurance regulators focus on whether the organization engages in the business of insurance. To this end, the most essential element to consider is whether the organization has assumed insurance risk. The acronym or ownership of an organization should not impact the decision whether an organization should be treated as a health insuring organization under the existing regulatory structure. This prin-

[5] Taylor, Roger S. and Craig Schub, *Medicare Risk Plans: The Health Plan's View*, Managed Health Care Handbook, Peter R. Kongstvedt, ed., 3d ed., 746 (Aspen 1996).

ciple applies to organizations that are provider-sponsored. Provider-sponsored organizations assume insurance risk and ought to be regulated like other health insuring organizations by the states.

State insurance regulation offers essential elements of an effective regulatory framework for organizations serving the Medicare managed care program. We urge you not to hinder the ability of the states to use their expertise and apply the standards appropriate to their market. Federal preemption of state insurance regulation will weaken protections for Medicare beneficiaries, further segment the health insurance market, and result in standards inappropriately tailored to some state insurance markets.

We appreciate the opportunity to testify before you today concerning the regulation of provider-sponsored organizations. The NAIC looks forward to working with the 105th Congress on this and other issues of mutual concern.

NATIONAL GOVERNORS' ASSOCIATION
NATIONAL CONFERENCE OF STATE LEGISLATURES
March 19, 1997

The Honorable MICHAEL BILIRAKIS
Chairman, Subcommittee on Health and Environment
Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

DEAR CHAIRMAN BILIRAKIS: On behalf of the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL), we are writing to express support for the positions set forth in the testimony of the National Association of Insurance Commissioners (NAIC) regarding the regulation of provider-sponsored organizations (PSOs).

The regulation of health care networks is currently and should continue to be the responsibility of the states. Based on states' experience, we believe that all insurers, regardless of sponsor, should be treated similarly. We believe there are no substantive differences between provider-sponsored health insurers and other health insuring organizations. Due to the hard work of governors, state legislators and insurance commissioners from across the country, states have established a level playing field in the private market through the imposition of standardized licensing requirements, the enforcement of comparable quality assurance and solvency standards, and the establishment and enforcement of essential consumer protections. These standards and requirements differ among the states, reflecting difference in the structure and conduct of the health care market in the fifty states.

Federal preemption of state regulatory authority in this area will adversely affect the health care delivery system by creating additional fragmentation and complexity in the market. We believe that a partnership between the states and the federal government, built on the foundation of the existing state regulatory structure, is the best way to assure Medicare recipients that they will receive the high quality health care services they desire.

In summary, we believe: (1) states should continue to regulate all health care networks; (2) provider-sponsored health insurance organizations are not substantively different from other health insuring organizations; and (3) a partnership between the states and the federal government should be established, built on the existing state regulatory structure to assure that the appropriate oversight of provider-sponsored health insurance organizations occurs. We urge you to carefully consider the testimony presented today by the NAIC and we look forward to working with you to establish a partnership to assure the appropriate oversight of provider-sponsored organizations.

Sincerely,

RAYMOND C. SCHEPPACH, *Executive Director*
National Governors' Association

CARL TUBBESING, *Deputy Executive Director*
National Conference of State Legislatures

Mr. BILIRAKIS. Thank you, sir.

Well, there's the 50/50 rule which requires, you know, the Medicare HMOs to have enrollment including 50 percent Medicare beneficiaries and the other 50 percent commercial enrollees. Could each of you explain to the committee the effect of this rule, maybe the purpose behind the rule, the effect, based on your experience of the

rule, particularly on quality? Is it useful? Is it something that should be continued? Is it something that should be continued insofar as provider service networks are concerned?

Mr. Bluhm.

Mr. BLUHM. I'm afraid I probably don't have anything to add.

Mr. BILIRAKIS. Nothing at all to add?

Mr. BLUHM. No.

Mr. BILIRAKIS. Okay. All right. Mr. Pomeroy.

Mr. POMEROY. Dave.

Mr. BILIRAKIS. Mr. Randall.

Mr. RANDALL. Mr. Chairman, the 50/50 rule, my understanding of it and how the States recognize it is that it, in essence, is utilized to make certain that there is adequate quality associated with plans that are contracting with the Medicare program.

In terms of how it works in reality, in terms of the State process which we go through in making certifications back to HCFA, it definitely has a lot of practical implication. What I mean by that is that these plans are providing quality standards that are necessary.

In fact, we refer to, in both our oral presentation and in written comments submitted to the committee, is that the health plan accountability standards that the NAIC has developed, which many States are in the process of implementing, we think will go a long way in making certain that quality is preserved.

Mr. BILIRAKIS. Do you feel that they continue to be necessary for just the regular HMO, not the provider service network?

Mr. RANDALL. Absolutely. Those quality standards are essential to make certain that consumers are being served.

Mr. BILIRAKIS. You think that the 50/50 rule should continue to be used?

Mr. RANDALL. My personal opinion is that it should be repealed.

Mr. BILIRAKIS. Should it be repealed?

Mr. RANDALL. Yes.

Mr. BILIRAKIS. In every case? Mr. Pomeroy, do you agree?

Mr. POMEROY. Mr. Chairman, the organization does not have an official position on this question. I do recognize that the 50/50 rule poses some challenges for rural States like mine and certainly applaud the committee's efforts to look at that rule. We don't have a specific recommendation for me to make.

Mr. BILIRAKIS. Do you have a personal opinion, though, outside of the scope of——

Mr. POMEROY. I personally appreciate the attempt to ensure quality, which the rule seeks to provide, although I do think there are other ways to ensure that quality, such as the protections that we've been discussing here this afternoon.

Mr. BILIRAKIS. Well, now, Mr. Pomeroy, your jurisdiction is a very rural one. Some of the strongest advocacy, as we heard from our members on behalf of PSOs, has come from rural health care providers. They argue that rural areas, traditionally avoided by managed care plans—Mr. Stenholm shared his experience with us—would be attractive to PSOs, because PSOs would not need the same large commitment of capital and infrastructure as required by most managed care plans.

Do you think it's possible to successfully broaden choices for rural areas without subjecting them to the risk of insolvency?

Mr. POMEROY. Mr. Chairman, we have to move kind of slow in North Dakota. In fact, I think probably in my jurisdiction there's—in no other jurisdiction is there a smaller market for a revolution in managed care. I think that's changing over time, but from my perspective it's important that, if it's going to change, and if more of our population, particularly the Medicare population, moves into a managed care context, that they do so being fully protected and receiving all of the consumer protections that other consumers in my State receive.

I believe that choice will broaden over time. We recently licensed, for example, an HMO that is based out of a hospital and clinic in the community. We have a flexible regulatory framework so that we can work with the entities that are seeking to obtain a foothold in my State. I believe that consumers benefit from choice, provided that the choices are good ones and don't subject the consumer to ultimately assuming the risk, as you mentioned in your opening remarks.

Mr. BILIRAKIS. Anything to add to that?

Mr. RANDALL. In terms of some of the issues that Mr. Greenwood and Mr. Stenholm raised in their testimony on H.R. 475, I can tell you Ohio certainly has a rural component, including some areas in Mr. Brown's district. All 38 counties in the State have HMO penetration. In fact, of the HMOs that we have licensed in the last 2 years, about half of them have been in rural areas. So, from that perspective, they have met the solvency standards and are providing care in rural areas, as well.

Mr. BILIRAKIS. Thank you. My time has expired.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I'd like to follow up on his line of questioning. Both Mr. Randall and Mr. Pomeroy indicated that State regulation is appropriate because there are differences in health insurance markets throughout the country, in part because States have experienced differing levels of managed care penetration.

Why are different standards appropriate based on the degree of managed care penetration? If different standards are appropriate for different areas of the country, wouldn't this imply that perhaps in rural areas there is a need for different standards? For example, lowering minimum enrollment requirements, is that something we should do?

Mr. POMEROY. I don't have a specific response to the minimum enrollment periods at this time, but I think the need for flexible standards is self-evident. States are clearly different, one from the other. The marketplace in North Dakota is vastly different from the marketplace in New York or California.

We have worked, over time, to be responsive to the needs of our market. We have enacted, for example, model legislation, yet tailored to our own individual State's needs, so that we can allow the managed care marketplace to develop, but do so in such a way that the consumers have the necessary protection.

We, along with all other States, believe that a "one size fits all" framework does not work very well and presents not only problems

in implementation but perhaps unintended consequences that might ultimately be counterproductive to what this committee's objectives might otherwise be.

Mr. RANDALL. Mr. Chairman, Mr. Brown, I certainly concur with my colleague. In fact, in Ohio, we've certainly gone to great lengths to make certain that those rural HMOs get the assistance of the department in terms of going through the licensure process. I think it's been helpful in terms of getting them up and running and up and started.

I guess the one thing that I'd like to emphasize, which certainly Commissioner Pomeroy emphasized in his statement, as well, solvency considerations are absolutely key and fundamental, in terms of what all of you should, from our perspective, be examining in this debate, as well as what the States have examined, as well.

Because, frankly, the insolvencies that have occurred, at least in Ohio, have been in those plans that were small, low enrollment, and low capitalization standards. I think that that certainly emphasizes the fact that solvency standards have definite meaning for consumers.

Mr. BROWN. Several provider organizations have been in to see me in the last few days and talked about different solvency standards, because providers, they say, are in the business of providing services directly, while insurers are in the business of profiting from the purchase and resale of health care services.

They have argued that providers don't need to maintain substantial liquid assets like insurers, because they have assets that are concentrated, actually, in health care delivery, and they have the capacity to deliver the services for which they assume risk, whereas insurers do not, by nature of the businesses. They also argue that providers can sustain themselves longer without liquid reserves because of those health care delivery assets.

Comment on that, if you would.

Mr. POMEROY. The bottom line is, from our perspective, any entity, regardless of how it's formed, that ultimately assumes the risk, that ultimately contracts with individuals, employers, or other groups, and says, "We will pay for your health care needs; you pay us a certain amount of money, and we will pay for your health care needs, even if those costs ultimately outstrip what you have paid in premium," that is an assumption of risk that requires consumer protections.

It's fine for providers—and I appreciate and acknowledge the point that a portion of what they do is providing direct services, but that plan has other costs associated with it, as well, administrative costs, facility costs, and other costs that are not controllable simply by rolling back one individual's salary for a few months while the costs and expenses become more in line.

So we don't feel that the suggestion by the providers that similar regulation may not apply in this case because there are physician services involved—we fundamentally disagree with that point and are very concerned about that approach to the market.

Mr. BLUHM. I think it's important to keep in mind the difference between liquidity issues and the capital issues. The argument of whether there is sufficient liquidity to fund the cash-flows over a period of time is, in the Academy's thinking, a separate issue from

the issue of whether there are sufficient assets to cover the liabilities, which is what defines solvency.

Mr. BROWN. Mr. Chairman, thank you. I yield back.

Mr. BILIRAKIS. All right. A vote apparently has been called on the floor, so we're going to recess for just a few minutes until we can return. Thank you.

[Brief recess.]

Mr. BILIRAKIS. Let's get started, please.

Mr. Pallone, to inquire.

Mr. PALLONE. Thank you, Mr. Chairman.

I just wanted to say, as I said in my opening statement, that I am a big advocate of PSOs, and I know that in New Jersey, in particular, a number have started and are operating, again, under the existing laws, I suppose with regard to HMOs.

Listening to Mr. Pomeroy's testimony, in particular, it seems to make sense what he's saying about how the regulation, if you would, should be by function. Also, I tend to think that, on the Federal level—I mean, usually, on the Federal level, what we do is, we'll set a minimum Federal standard and then let States be more stringent in what they do.

It seems like what's being advocated here is just the opposite, that somehow the States are maybe too stringent or not flexible enough, and therefore there should be some kind of Federal preemption in order to allow for less stringency or more flexibility, which is a little strange, at least in my mind. Maybe there are some examples where we do that, but it seems, in most of the cases, it's the opposite.

So I guess I really don't understand the theory—and maybe you are not the right ones to ask—but I really don't understand the theory about why the Federal Government should get involved and not let those PSOs that don't qualify right now, under State standards, to simply go about their business of trying to convince the States to address some of the problems that have been raised.

Again, I don't know if you're the right people to respond to that, but go ahead.

Mr. POMEROY. Mr. Chairman and Congressman, I do have a response. These organizations are developing. They do exist in New Jersey and in many other States.

In our formal written testimony that we submitted, we cited a recent NAIC survey that we've been working on. Thirty-nine States have responded to this survey so far and, at least in 27 of the 39 responding States, there are organizations that are licensed that are under control by providers. This entity structure is developing, but fortunately it's developing under the proper oversight of the States. We think it should continue to be that way.

Mr. PALLONE. Well, let me ask you this: Is any effort being made, on the State level, to address some of the concerns that are being raised by those that want to do more with PSOs, the smaller ones, the ones in the rural areas?

Mr. POMEROY. Congressman, yes, and that's a very good question. We recognize that these organizations, though assuming risk, because of their nature are also somewhat different than some of the other insuring organizations that we regulate.

We have been developing, for some time, something that's called the risk-based capital formula for health organizations such as these. This formula which is under construction at the NAIC—I think Mr. Randall touched upon it—isn't quite completed, but it should be by this summer.

The construction of this formula, which sets minimum standards for these organizations, has been done in a very open way. We have received an enormous amount of input from not only insurers but from provider organizations and from the medical associations.

We believe that this formula will be sensitive to some of these considerations and provide basic minimum formulas which States then will be able to put on their books, which will make sure that the regulatory framework is flexible enough to account for the slightly different approaches these entities bring into the States, without sacrificing the fundamental consumer protections.

Mr. PALLONE. So then you don't really believe—in other words, none of you, I guess, obviously, really believe that the effort to expand PSOs, particularly because some of them are smaller, or whatever, that that effort is really being inhibited that much right now?

Mr. RANDALL. Mr. Chairman, if I may.

Mr. Pallone, no, I do not. In fact, I think just the opposite has occurred. For instance, in my own State of Ohio, we have gone out of our way to assist PSOs and physician- and provider-based organizations, to assist them in getting licensed as health maintenance organizations under our statutes.

In fact, in Ohio, we have 43 licensed HMOs. Only California has more as of this date. In fact, 9 of those organizations, most of which have been licensed in the last 18 months, are provider owned and controlled, and many of them are in rural areas.

So I think, from that perspective, as a specific State example, we have attempted to assist provider organizations with the eye on solvency and consumer protection and allowing them to compete and operate in the marketplace.

Mr. PALLONE. Mr. Chairman, do I have time for one more question?

Mr. BILIRAKIS. Yes, you do.

Mr. PALLONE. I noticed, in Mr. Bluhm's testimony, he said that most of the solvency standards applicable to health insurance risk-bearing entities today are part of the current State regulatory framework, and then he lists them. And he says few of these solvency mechanisms currently apply to PSOs.

Would you just explain that again for me? Is that because these are for insurance entities, and the PSOs don't qualify?

Mr. BLUHM. Right. That's the essence of it.

Mr. PALLONE. But yet the HMOs do?

Mr. BLUHM. Right. If they become an HMO, then they would be subject to them.

Mr. PALLONE. That's because HMOs are insurers and PSOs aren't? I don't quite understand.

Mr. BLUHM. Well, typically, unless there is special State legislation, PSOs are not a normal licensed entity.

Mr. PALLONE. Oh, so that's the reason.

Mr. BLUHM. So they are, therefore, not subject to any of those solvency regs.

Mr. PALLONE. Unless they qualify as an HMO, then they wouldn't be subject to those standards.

Mr. BLUHM. Right, or some other State licensed entity that is allowed to provide services.

Mr. PALLONE. Okay. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired.

Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman.

I ask the indulgence of the witnesses. On such an important issue, it's very frustrating, at least to me—I'm sure it is to other members—that we have to pop up and down and run in and out, and then try to stitch together what your testimony is about.

Since I haven't heard all of it, but I know what you submitted and I got just a little bit before I left, I understand that you support that States should remain as the entity charged with the licensure, the regulation, and the oversight of organizations that are in the business of being at risk for the provision of health care services.

Just to be devil's advocate, convince me that you are not presenting this simply because you are territorial. Excuse the expression. But you very often find that once one agency or a State or the Federal Government—they become very vested in their own position and say, because we're doing it, that we should be the only ones that are doing it.

So I think that I'll just kind of turn it around. Convince me that you're not being territorial, and perhaps touch on why you think the Federal Government should not be involved in what you're doing now. Is it incompetent? I know there are people here that think it's incompetent. But, I mean, in a sophisticated sense, where do you think the incompetency or the shortcomings lie?

And you even have the right name in front of you. I mean, your name is famous around here. It's a good name as far as I'm concerned.

Mr. POMEROY. Thank you, Congresswoman.

Ms. ESHOO. I always call your brother the senator of our class, but you're both elected statewide.

Mr. POMEROY. I am a very last minute substitute for the president of the NAIC, who was not able to be here this morning.

First of all, I appreciate your question. We have plenty to do, and it is not something that we need to go around trying to keep something on our plate.

Ms. ESHOO. What makes you want to keep doing it?

Mr. POMEROY. Okay. Our fundamental motivation is the commitment that we have to our consumers. We believe that consumer protection is paramount in the work of insurance regulation. When an entity assumes risk, there is reason to lay in that consumer protection, not just in terms of solvency regulation, but market conduct issues and the other functions that we perform. We believe that we ought to keep performing them for the benefit of those consumers, regardless of how the entity is structured or what acronym is associated with it.

The States have the experience in providing that consumer protection.

Ms. ESHOO. All of the States do?

Mr. POMEROY. Yes. Transferring that responsibility to the Federal Government, which not only lacks the experience but doesn't have the current infrastructure, we just don't think makes good sense, and puts at risk, we think, these consumer protections.

Ms. ESHOO. How much consistency is there between the 50 States now and what they have on the books?

Mr. POMEROY. There is a great deal of consistency, although yet flexibility which allows for tailoring regulations to the individual States.

Ms. ESHOO. It's the big buzz word, "flexibility."

Mr. POMEROY. Yes.

Ms. ESHOO. Until you break it down, it's, you know—it means different things at different times.

Mr. POMEROY. But State insurance regulators, really, across the board, are doing a good job. We've developed an accreditation program, for example, to ensure that all States meet a certain mark, in terms of providing for the solvency protection for the entities that are insuring and located in those States.

The NAIC rolls out a number of model laws and model regulations designed to set benchmarks which States then take back home and enact through their State legislatures.

Ms. ESHOO. Just to interrupt, because we don't want to miss the vote. Can you give me an example of, under the State's jurisdiction, where there was a shortcoming in a program and, because of the State's having just something absolutely wonderful on the books, they were able to step in and take care of it, and protect the consumer? Give me a case, an example.

Mr. POMEROY. Okay. If you don't tell your colleague and my brother that I told you this.

Ms. ESHOO. No, I won't make that promise; I'm sorry.

Mr. POMEROY. In my little State of North Dakota, there was an HMO that was formed back in the early 1980's, before these protections had evolved, and this organization grew too fast, did not have the proper financial solvency protections. Essentially, then Commissioner Earl Pomeroy had to liquidate this organization and spent a long time trying to make sure that enrollees in that program received the coverage that they thought when they enrolled in that program.

Ms. ESHOO. Actually, I think, on a serious note, he did share that with me some time ago, in terms of experience. Thank you.

Mr. Chairman, are we going to miss our vote? Did you already vote?

Mr. BILIRAKIS. I did not already vote.

Listen, I wanted to finish up, though, with you, Anna. Have you finished your questioning?

Ms. ESHOO. Yes. Well, I think, in the interest of time, I had best stop.

Mr. BILIRAKIS. Did you have something, very quickly, Mr. Randall, that you wanted to add?

Mr. RANDALL. Just as a follow-up, Mr. Chairman. The same situations have occurred in Ohio, and I know in other States, where

regulators were able to act very quickly, in terms of solvency considerations, to protect consumers.

Mr. BILIRAKIS. Okay. Mr. Bluhm.

Mr. BLUHM. I just wanted to express that the Academy doesn't take positions, so we don't have a position, necessarily, that State regulation should be the way to go. Our warning was that, if you don't go that way, there are some major implications because of it that are consistent with what the other gentlemen have said.

Mr. BILIRAKIS. All right. Thank you. I'm going to excuse this panel. I want to apologize to you. And, of course, so many people in this room have gone through this so often over the years that they understand what's going on here. I'm not sure that I do sometimes. After this vote, I've been told that we expect three more votes, and we're talking about 10 minutes, debatable times, for each one of them. I can only guess.

I'm going to recess until maybe 3:45, which is 50 minutes from now. Hopefully, that will catch it, because I think it's just terrible to go running back and forth this way, and also it's unfair to the rest of you. We'll do our best. Thank you.

Mr. POMEROY. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you very much.

[Brief recess.]

Mr. BILIRAKIS. Show time.

The third panel consists of the Hon. Bill Gradison, president of the Health Insurance Association of America; Ms. Mary Nell Lehnhard, senior vice president, Office of Policy and Representation, Blue Cross and Blue Shield Association; Mr. Thomas R. Sobocinski, president and CEO of Physicians Plus Insurance Corporation, representing the American Association of Health Plans; Dr. Richard F. Corlin, Speaker of the House of Delegates, American Medical Association; Mr. John C. McMeekin, president and CEO, Crozer-Keystone Health System, representing the American Hospital Association; and Dr. Robert Margolis, chairman of the American Medical Group Association.

Welcome to all of you, and we apologize for the delays. Thank you for your patience. Chances are, before we finish this panel, we will be called for another vote, but we will do the best we can in the meantime.

Let's start off with Mr. Gradison.

STATEMENTS OF BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, OFFICE OF POLICY AND REPRESENTATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION; ROBERT MARGOLIS, CHAIRMAN, AMERICAN MEDICAL GROUP ASSOCIATION; JOHN C. McMEEKIN, PRESIDENT AND CEO, CROZER-KEYSTONE HEALTH SYSTEM, REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION; THOMAS R. SOBOCINSKI, PRESIDENT AND CEO, PHYSICIANS PLUS INSURANCE CORPORATION, REPRESENTING THE AMERICAN ASSOCIATION OF HEALTH PLANS; AND RICHARD F. CORLIN, SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

Mr. GRADISON. Thank you, Mr. Chairman.

I am Bill Gradison, president of the Health Insurance Association of America. My remarks today focus on the proposals related to solvency requirements for provider-sponsored organizations.

Our main concerns are twofold. First, several initiatives which you are considering would allow a new category of Medicare risk contractors, federally sponsored PSOs, to be exempt from existing State licensing requirements, particularly in the area of solvency. This exemption would, in our opinion, result in a significant reduction in consumer protections for Medicare beneficiaries.

Second, if Federal solvency standards are eventually allowed to replace existing State solvency requirements, there are broad implications for the commercial health care market. A PSO could move from operating in the Medicare market to the commercial HMO market, having never satisfied State solvency requirements as they currently exist.

The need for solvency, obviously, is a governing principle in business. An entity that doesn't have enough money to meet its obligations is considered insolvent. Now, our concern is that future Federal solvency standards may allow a PSO to count their fixed assets, such as facilities, equipment, and land, as admissible for satisfying solvency standards.

This could lead to insolvency, as such assets cannot always be readily converted to needed cash. I think this is the heart of the issue. The liquidity of an asset is not determined by its owner but by the nature of the asset.

After all, not all care within a PSO is rendered by providers within that organization. For example, when a senior citizen needs costly specialty care from providers out of town, the PSO still has to find some way to pay for that care. With regard to a hospital, even if the doctors are willing to work for free, nurses have to be paid, bills have to be paid for food and for pharmaceuticals, to state the obvious.

Medicare beneficiaries should be protected by experienced regulators who have responsibility for the continual monitoring of a health plan's financial status. If the financial requirements for risk contractors are set too low, the obvious question is, to whom will the unpaid parties turn if a health care plan fails?

Under the legislation you are considering, it is far from clear. My impression is that the Treasury would be intended to foot the bill, that is, for charges incurred by the health plan prior to the time it became insolvent. The beneficiaries, presumably, would fall back on fee-for-service Medicare.

Obviously, America's senior citizens really shouldn't have to worry about the solvency of the plans which provide their care. That's the charge for the regulators, the responsibility of the regulators, whether you turn it over to the Federal regulators or to the State regulators.

Mr. Chairman, there is a larger issue at stake here than whether PSOs should be federally licensed for Medicare, important as that is. The question is, how do you wish to divide the future regulatory responsibility for all health insurers and health plans?

I believe that Federal licensing of Medicare PSOs will, over time, tip the scales toward a much larger Federal role. Seeking a level playing field, non-PSO HMOs may seek Federal approval for their

Medicare coverages. If the Federal agencies buildup expertise in regulating health plans for Medicare, similar treatment for plans serving the Medicaid program may well follow.

In bringing this up, Mr. Chairman, all I'm trying to do is indicate that, in my opinion, what you are contemplating will move us in a certain direction. If you take this step, please keep in mind what it means further down the road.

Thank you, Mr. Chairman.

[The prepared statement of Bill Gradison follows:]

PREPARED STATEMENT OF HON. BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman, I am Bill Gradison, President of the Health Insurance Association of America (HIAA). HIAA is a trade association representing more than 250 companies in the business of providing health coverage. We welcome your invitation to address your subcommittee today on provider sponsored organizations (PSOs) and the Medicare marketplace.

Although HIAA has an interest in many aspects of the current debate on Medicare reform in the Congress, today I will focus on specific proposals related to PSOs as eligible organizations in the Health Care Financing Administration (HCFA) Medicare risk contracting business.

My concerns related to these proposals are:

- Several initiatives would allow for a new category of Medicare risk contractors, e.g. "federally sponsored" PSOs, to be exempt from existing state licensing requirements, particularly in the area of solvency. This exemption is a blatant reduction in consumer protection standards for Medicare beneficiaries. Proposals allowing lower minimum enrollment levels for PSOs could also exacerbate the potential for insolvency for these entities.
- If federal solvency standards are eventually allowed to replace existing state solvency requirements, there are implications for the commercial health care market. It is possible that a PSO could move from operating in the Medicare market to the commercial HMO market as a state licensed HMO never having once satisfied the PSO's respective state solvency requirements as they currently exist.

Mr. Chairman, HIAA supports the expansion of additional choices for Medicare beneficiaries. However, the Administration and the Congress must exercise responsibility to make certain that contractors in the Medicare risk market are financially viable, and bring to their enrollees the same consumer protections standards that are in the Medicare risk program now.

PSOs and Solvency Defined

Several proposals before the Congress allow for "federally sponsored" PSOs to apply for a waiver of state licensing requirements in the area of solvency and capital adequacy, the very same state licensing requirements that are required of a Medicare risk applicant today. This waiver of state licensing requirements appears to be in the area of solvency and capital adequacy.

We need to be clear as to what constitutes solvency. Solvency is a governing principle in business; an entity or business that does not bring in enough money to meet its obligations is considered insolvent. The most common solvency standard is "cash flow"—the availability of premiums, or in this case the availability of the Medicare Adjusted Average Per Capita Costs (AAPCC) reimbursements, to meet financial obligations as they come due. Insolvency is defined as liabilities exceeding assets. Most businesses borrow money, develop and sell products with a profit margin to repay their creditors. Thus, insolvency is primarily a risk to creditors. Insurance risk is different.

Eligible organizations contracting with HCFA for risk contracts accept the AAPCC in exchange for providing Medicare benefits to enrollees. Federal payments are received for an enrolled population with the promise to provide a defined set of benefits. This promise creates an "insurance risk" and insolvency primarily affects the insured, which in this case in the nation's senior population. HIAA believes that insurance risk is different, the population affected is different, and that PSOs, being virtually identical to traditional HMOs, should have to meet the same regulation and solvency standards.

The Administration and the Congress cannot afford to allow PSOs in the Medicare marketplace with lower standards for solvency protections than are currently required through the state licensing process for risk bearing entities.

PSOs are Regulated Now

PSOs, whether they constitute groups of physicians or hospitals, or a combination of both, are eager to enter into the Medicare risk contracting business. These providers, involved in the ownership of these organizations, should not be exempt, or held any less accountable, in meeting state financial requirements and consumer protection standards.

In today's health care marketplace, there are PSOs operating as HMOs. They are organized under the laws of their respective states and have demonstrated to their states adequate experience in management of insurance risk. Additional PSOs that wish to be in the Medicare risk business should not be allowed an exemption from the very requirements or standards that are designed to protect consumers, in this case aged and disabled Medicare enrollees, from the risk of insolvency.

It is extremely risky to exempt Medicare contractors from adequate state solvency requirements. Moving the entire health care market over time under these "softer" solvency requirements is cause for even greater concern. HIAA reiterates its position that states are in the best position to regulate risk bearing health care entities operating at the state and local level. PSOs in the Medicare risk program, and elsewhere, should look and act like state licensed HMOs.

States should remain as the entity charged with the licensure, regulation, and oversight of organizations that are in the business of being at risk for the provisions of health care services. The state regulatory system has worked well to protect consumers. It does not need to be replaced with a separate regulatory process just for "federally sponsored" PSOs. State solvency requirements have a proven track record and are accompanied by consumer protection features in the event of insolvency.

PSOs and the Commercial Marketplace

Several initiatives call for federal solvency standards to be applied to "federally sponsored" PSOs for the period 1998 through 2001 solely for the Medicare risk program. By the year 2002, however, several proposals call for all state solvency requirements to be pre-empted by the federal solvency requirements. This means that a PSO could be exempt from its respective state solvency requirements during its initial years in the Medicare marketplace and then enter the commercial marketplace never having once satisfied the state consumer protection and solvency requirements in those states where it operates or seeks to enter.

HIAA reiterates its position that states are in the best position to regulate risk bearing health care entities operating at the state and local level. PSOs look and act like state-licensed HMOs.

State Solvency Requirements

There are many reasons why a health plan may become insolvent—adverse risk selection, less than adequate enrollment of members, increases in anticipated utilization, inability to control costs, are a few key factors. Nearly all states require that HMOs maintain a minimum net worth as well as amounts on deposit with an appropriate state agency or independent organization to pay claims in the event of insolvency. Forty-one states require that HMO members may not be held responsible for the cost of covered services in the event of their plan's insolvency. A majority of states also require the providers in the HMO network to continue coverage for their members for a certain period of time in the event of insolvency. Therefore, if a licensed HMO becomes insolvent, state requirements offer some level of consumer protections to its members.

The Congress and the Administration should not experiment with new federal solvency requirements for inexperienced PSOs with the Medicare population. Seniors deserve the promise that the Federal government will do its best to protect them against the pending disaster of enrolling in a Medicare risk plan that does not have adequate financial protection standards.

Defining Assets is Key to Financial Stability

State solvency requirements start by establishing definitions of assets. The value of assets is a key component of solvency protection. Assets have two values—a monetary value and a business value. In an insolvency this difference is critical. In the matter of PSOs, the critical point is the difference in current monetary value and the previous business value of health care delivery assets.

PSOs that have assets in their facilities, equipment, and land do not necessarily have the ability to turn such assets into the funds necessary to pay for required health services. This is the heart of the issue. Liquidity of an asset is not determined by its owner but by its nature.

State insurance regulators have experience in addressing this dichotomy in a manner which protects the insured while promoting accessible and affordable insurance products. No similar federal experience exists.

When a senior citizen needs costly emergency care from providers out-of-town and his or her PSO has little cash on hand, where will the plan turn to ? Will it turn to the Federal government? Senior citizens should be protected by experienced state regulators implementing solvency protections.

Minimum Medicare Enrollment Levels for Risk Contractors

HIAA is concerned about proposals that would allow projected enrollment levels for PSO risk contractors to be 500 enrollees (down from the current requirement of 1500) in a rural area or 1500 enrollees in other areas (down from the current requirement of 5000). These changes violate the basic principle of the broad-based enrollment that is needed to sustain a viable risk program.

HIAA believes that a Medicare enrollment level of 500 in rural areas and 1500 in non-rural areas is too small a base for a viable Medicare risk program. For example, a single physician could barely survive financially with a practice panel limited to just 500 Medicare members. These levels, combined with pre-empted state solvency requirements, exacerbate the potential for financial failure.

Risk contractors need a viable enrollment base if they are to spread their risk and meet their obligations to provide, arrange, as well as pay for Medicare covered services. Caution should be exercised about changing enrollment requirements when such changes could lead to a greater chance for insolvency of a Medicare option.

Mr. Chairman, HIAA opposes establishing federal standards for PSOs applying to HCFA as Medicare risk contractors that are less stringent than those already in place on the state level.

Current HCFA requirements place the regulatory oversight of the eligible organization, whether that be an HMO or PSO, on the state level first where it appropriately belongs. At the same time current law allows HCFA to accept the entity as a contractor with the understanding that appropriate state licensing, solvency standards, and associated consumer protections have been met prior to the HCFA contracting process.

HIAA sees no reason for implementing dual state-federal standards for an interim period of time. The state licensing system, and all the consumer protection standards associated with such processes, must be preserved. It is the only way to guarantee the consumer protection standards needed for both Medicare beneficiaries and the American public at large.

If the solvency requirements for a risk contractor become minimized, who then will the seniors and the disabled turn to when their health plan fails? Is not one savings and loan crisis in America enough of a learning experience to make sure that such a situation does not happen again? And this time it could affect the health care of America's senior citizens.

Thank you, Mr. Chairman, for the opportunity to address you and Members of the Subcommittee. I am available, as always, for your questions.

Mr. BILIRAKIS. Thank you, Mr. Gradison.

Ms. Lehnhard, please proceed.

STATEMENT OF MARY NELL LEHNHARD

Ms. LEHNHARD. Mr. Chairman, members of the committee, I am Mary Nell Lehnhard, senior vice president of the Blue Cross and Blue Shield Association.

It is obvious today that the question is not whether PSOs should be Medicare risk plans—the answer is yes—but how they should be regulated. Blue Cross and Blue Shield plans believe that Congress would be brushing aside extremely important consumer protection laws if they exempt PSOs from the current Medicare requirement that all Medicare risk plans be licensed by the State.

A recent study on consumer State protection laws shows there are over 1,000 State consumer laws on the books that protect consumers under PSOs, HMOs, PPOs, any kind of managed care plan. Medicare law currently recognizes the importance of these State laws in protecting beneficiaries.

Medicare risk plans, right now HMOs, must meet a set of Federal standards and must be licensed by the State and meet all of those consumer laws in the State. The Federal Medicare requirements are, in essence, a floor for many States that go beyond the Federal requirements to protect consumers.

We believe that beneficiaries enrolled in Medicare PSOs deserve the same level of protection as beneficiaries that will continue to be enrolled in Medicare HMOs that are still licensed by the States. I think, very importantly, we don't believe Congress wants a situation where Medicare beneficiaries have to sit and talk to each other and figure out whether their health plan is regulated by the State or by the Federal Government. In other words, which set of consumer protection laws is my plan subject to?

This is especially important because State HMO laws often address problems that are unique to the State and very visible in that State. For example, a State may have a history of problems with the credentialing of physicians and take action on it. Thirty-two States have had problems with marketing abuses and now require their brokers to be certified and recertified every 2 years. That's not in the Medicare law.

In particular, it's a disservice to beneficiaries to waive State consumer laws that assure financial solvency. We've heard a lot about this today. After extensive debate, the State insurance commissioners, in the form of the NAIC HMO investment guidelines, have not been willing to take the risk of what Congress is considering. I think this is the most important thing I have to say today.

The Federal proposals would allow PSOs that accept capitation from Medicare to meet 100 percent of their minimum net worth requirements using their hospital buildings and physical assets. You have to understand that the minimum net worth requirements are what you have to have on hand, cash you have to have on hand to pay claims or health care costs that exceed your estimates. It's what the NAIC requires and what the States require. However, very importantly, you can't use your hospital to pay unexpected claims costs or patient costs.

This is really at the heart of why all State commissioners and the Governors are so opposed to waiving these financial standards. In fact, the proposed net worth test under the Federal proposal has the potential to push rural hospitals into financial default, because the only cushion they will have against unexpected patient care costs would be their facility. It would be at risk. The Federal proposals are essentially a strong message from Congress for providers to set up PSOs that are severely undercapitalized and very high-risk for consumers in the program.

These problems are particularly acute in rural areas. Our testimony summarizes a just-released study by Barron's of KGM Peat Marwick that highlights the particular high risk in rural areas. These include an unrealistically small number of people over which to spread the risk. These bills allow managed care entities of 500 people, a very high-risk population, because of accidents, age, and chronic illnesses, that will be difficult to manage, and most importantly, a very high use of out-of-network services that are going to require a substantial amount of cash on hand to pay for people when they go into the urban hospitals.

In closing, I want to emphasize that we think the answer to how to assure Medicare risk plans in rural areas is not to waive basic consumer protections for beneficiaries. The answer is to raise the Medicare payment levels in rural areas.

Once you do that, you will see a flood of interest among entities, PSOs, HMOs, that do have a State license, a flood of interest in partnering with PSOs and networks in rural areas. The small rural PSO won't have to assume the risk; its licensed, well capitalized partner can do that, and beneficiaries in rural areas will have both access and consumer protection.

[The prepared statement of Mary Nell Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUECROSS BLUESHIELD ASSOCIATION

Mr. Chairman, I am Mary Nell Lehnhard, the Senior Vice President for the Office of Policy and Representation of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present to the Commerce Committee the views of the 59 Blue Cross and Blue Shield Plans on the important topic of Provider Sponsored Organizations (PSOs).

BCBSA supports public policies that promote fair and vigorous competition because we believe this will expand the availability of affordable health care for all Americans. A healthy, competitive marketplace will best meet consumer demands for access to high quality health care—and we believe Provider Sponsored Organizations (PSOs) should be part of this marketplace.

BCBSA does not oppose the formation of PSOs. In fact, many Blue Cross and Blue Shield Plans partner with PSOs to create, deliver and manage innovative health plans.

However, we are opposed to proposals that would exempt PSOs that contract with Medicare from the current requirement that all Medicare risk plans meet both federal standards for HMOs *and* be licensed by the state as meeting all the consumer protection laws in that state. Contrary to provider assertions, existing state licensure requirements for HMOs do not prevent the development of health plans that are sponsored, controlled, and managed by providers. In fact, 14 percent of all licensed HMOs are provider controlled, i.e., PSOs.

Our testimony highlights our concerns that: 1) PSOs should be subject to current requirements that Medicare risk contractors meet *both* federal and state consumer protection rules. 2) Medicare beneficiaries should have the benefit of the protection of over 1000 state consumer protection laws that assure: appropriate financial standards; and adequate access to quality care. 3) Unlicensed rural PSOs could jeopardize delivery systems in rural areas.

PSOs Should Meet Current Medicare Risk Contract Standards Regarding Federal and State Consumer Protections

Providers have asked Congress to exempt PSOs from current Medicare risk contractor standards requiring compliance with state consumer protection rules. Under these requirements, federal law provides a minimum set of consumer protection standards with which all Medicare risk contractors must comply. This provides a national "floor" for consumer protection. Medicare law also requires Medicare risk contractors to be licensed by the state and comply with state consumer protection rules so that beneficiaries have the benefit of the strongest protection standards available.

We believe that an exemption of PSOs from state licensure standards is unnecessary and presents unacceptable risks for Medicare beneficiaries as well as the Medicare program itself.

Medicare simply is not the place to roadtest unlicensed health plans. Medicare beneficiaries enrolled in PSOs should have the same protections as their Medicare neighbors enrolled in state licensed HMOs.

States that experimented in the past with separate standards for Medicaid HMOs met with disastrous results. For instance, Florida waived commercial HMO license rules for Medicaid HMOs in the early 1990s and consequently faced widespread abuses, including the provision of poor and possibly life threatening care. Florida has since required these entities to comply with all commercial enrollee rules.

Moreover, recent research indicates most PSOs are just emerging and are inexperienced in managing health care risk assumption. A 1996 survey by Ernst and Young on Integrated Delivery and Financial Systems indicated 71 percent of PSOs

were less than three years old. Twenty percent of PSOs reported losing money last year, but most troubling of all—nearly 40 percent of survey participants did not track the amount of revenue received and 20 percent did not know whether they were profitable or not. The business of managing risk requires a complex set of skills and competencies; emerging PSOs need close monitoring at the local level.

Medicare Beneficiaries Should Have the Benefit of State Consumer Protection Rules

Recent research by consumer attorney Carol Jimenez documents over 1000 state laws that currently protect consumers in prepaid health plans. These laws address a myriad of issues but are generally designed to assure two objectives: 1) The health plan is financially sound and ethically operated. 2) The consumer has adequate access to quality care from the health plan.

If Congress exempts PSOs from state licensure, Medicare beneficiaries enrolled in PSOs will not have access to the same level of protections as their Medicare neighbors enrolled in a state licensed Medicare HMO.

1) Consumer Protection: Financial Standards

The driving force behind consumers' enrolling in a health plan is their desire for security regarding future health care expenses as well as obtaining needed health care.

Financial standards (e.g. minimum net worth, investment rules, etc.) are the primary mechanism by which states assure consumers that a health plan will be capable of paying for its enrollees' health care needs currently and in the future. In today's ultra-competitive health care market, such standards are necessary to assure that health plans have a financial cushion to protect against the implications of aggressively underpricing products to jump-start sales, loss of market share, unanticipated increases in utilization, or the enrollment of particularly high risk individuals.

PSOs claim they can be exempt from state requirements to hold minimum net worth standards in cash or cash equivalent assets because: 1. They have substantial assets (investments) in hospital plant and real estate; and 2. They employ the staff that provide care, and this staff's "sweat equity"—the ability to work longer hours for no additional pay—will provide a cushion if a higher than predicted number of subscribers fall ill.

These arguments fail to adequately address the underlying reasons for the application of minimum net worth and investment standards to risk-bearing entities. These rules assure the existence of a financial cushion that PSOs—like other health plans—need to cover both internal and external costs:

- Internal Network Costs: PSOs, like other entities, must cover expenses incurred in providing services. Even if physician owners were willing to work longer hours at no cost, PSOs would still incur the expenses of nurses, physical therapists, and others that are not owners. In the case of hospitals, there is little room to use "sweat equity." Seventy-five percent of hospital expenses are labor related, e.g., nurses, nurses' aides, cleaning and maintenance staff, etc. In addition, an unexpected level of patient illnesses would require cash payments for expensive pharmaceuticals, surgical kits and other hospital supplies.
- External Costs: PSOs must be able to pay for a subscriber's emergency care that is obtained from hospitals that are not part of the PSO and tertiary care such as open heart surgery or cancer treatment that the PSO's hospitals and physicians cannot provide.

In cases where a PSO fails to adequately estimate their patient care costs and lack a liquid—that is, cash equivalent—financial cushion, the PSO would be forced to borrow against or even sell its delivery assets. These buildings and equipment are the very items the PSO relies upon in order to deliver services.

States limit the investments that prepaid health plans can make in land, buildings or equipment because these assets, while valuable, cannot be readily converted into the cash needed to pay unexpected claims or to pay for out of network care.

State investment rules assure health plans can still pay claims even when plans incur unexpected underwriting losses. Otherwise, consumers could be left footing the bill when their health plan encounters cash flow problems or becomes insolvent.

The same investment standards must be applied to all risk bearing entities—insurers, HMOs, PSOs, or whatever other organizations evolve, in order to provide consistent protection for consumers.

2) Consumer Protection: State Standards for Access and Quality

According to consumer attorney Carol Jimenez, there is nothing "magical" about Provider Sponsored Organizations that would warrant exemption from consumer protection rules. She states that PSOs are virtually indistinguishable from HMOs from a consumer's perspective.

Jimenez also dismisses PSO arguments that providers are less likely than HMOs to let financial pressures influence patient care. In fact, in a PSO there are likely to be fewer layers to give a financial cushion for the provider rendering care. Consequently, she argues that these entities must be subject to the same standards that states impose on local HMOs. Exemption from licensing standards for PSOs would mean beneficiaries in these PSOs would have *separate and unequal protections* from their neighbors who are enrolled in state licensed Medicare HMOs.

An exemption from state law would mean PSOs would not need to comply with state law, including:

- *Quality Assurance Laws:* States require health plans to develop and implement quality assurance plans, undergo external monitoring, and implement procedures for verifying the credentials of physicians and other providers. Other laws address utilization review.
- *Marketing and Enrollment Laws:* State laws prevent false and misleading advertising and eliminate practices designed to deny enrollment or continued enrollment to persons based on their health status.
- *Data Collection:* State laws require HMOs to track enrollee grievances, malpractice claims and report to the state. Other items required include patient outcome data and utilization data.
- *Access and Benefit Laws:* State laws regulate specialty care referrals, minimum time or distance that members should travel to obtain primary or other care as well as mandated benefits.
- *Grievance Procedures:* All states require health plans to establish grievance procedures through which a member can appeal what he or she believes is an unjustified denial of coverage.
- Conflicts of Interests State laws require HMOs to disclose any potential conflicts of interest and maintain a fidelity bond for those administering HMO funds.

Unlicensed Rural PSOs Could Jeopardize Rural Consumers Access To Health Care.

PSO advocates argue that a PSO exemption from state law is necessary to expand access in rural areas. However, a recent report released by the Barents Group indicates that unlicensed PSOs could exacerbate current health care delivery problems in rural communities.

The report, "Are Unlicensed Plans Risky In Rural Communities?" concludes that the cumulative effects of the rural environment make financial standards even more critical for a rural PSO than for those in urban areas. Barents documents the unique challenges faced by rural health care delivery systems:

- *The prevalent use of out-of-area and out-of-network health care services by rural residents.* A review of rural research studies demonstrates that rural residents frequently travel outside of their local community for health care services. In fact, 60 to 80 percent of rural residents have traveled outside of their local area for hospitalization at some point in time. Rural residents receive treatment from nonlocal hospitals for numerous reasons, including emergency and tertiary care. Out-of-area services require cash payments by rural PSOs. This is one of the primary reasons states impose financial standards on risk bearing entities. PSO advocates argue that PSOs do not need to comply with state financial standards because "sweat equity" will allow providers to work long hours without increasing costs. But "sweat equity" cannot be used to pay for out-of-network services.

  In addition, a high rate of out-of-area services severely constrains the ability of PSOs to manage the continuum of care—a managed care entity's most important cost control tool. As a result, rural PSOs may face a more volatile cost structure than those in urban or suburban areas.
- *A shortage of providers.* The shortage of health care providers in rural areas may make it difficult for PSOs to negotiate traditional risk-sharing arrangements with providers or influence provider practice patterns. Both risk-sharing arrangements and utilization review and management are critical methods through which managed care entities stabilize their costs.
- *The potential for adverse selection.* Rural PSOs face an accentuated risk for adverse selection because they operate in areas with small populations and a high rate of serious injuries. The challenges of rural health care suggest that PSOs would have difficulty attracting enough enrollees to spread their risks and to cover fixed administrative costs. A small population base limits the potential profit to be earned by a PSO even if costs are controlled. Yet the PSO remains at risk for substantial loss stemming from even a few enrollees with expensive illnesses.
- *Limited access to capital.* Rural PSOs will need substantial capital to initiate operations. Adequate capital is necessary to finance the claims payments systems, medical management programs and other systems essential for creating an ef-

fective rural managed care organization. More importantly, adequate initial capitalization is imperative to pay professionals who are qualified to administer claims and financial systems.

The collective historical experience of HMOs indicates that adequate capital is one of the principal indicators in determining success. Yet providers are now asking for special exemptions from capital requirements for PSOs. Specifically, PSOs would like to count hospital plant and equipment toward solvency standards. However, these assets—while valuable—cannot readily be converted to cash to pay for unexpected health costs and prevent cash flow crises. Exemptions from state licensure (i.e. solvency and liquidity requirements) could result in undercapitalized PSOs endangering health care delivery assets in rural communities.

The financial failure of—or even significant cash flow problems with—a rural PSO could have devastating effects on local rural providers. Local providers could be left with large unpaid bills and community hospitals—which are already financially distressed—could finally be forced to close their doors. The closure of a hospital would exacerbate current access problems as well as have a profound impact on employment and the overall local economy.

In a rural area where the loss of even one provider causes serious problems, the financial stability of a PSO is a great concern. Policymakers must ensure that the standards developed for PSOs reflect the unique characteristics of health care delivery in rural areas, especially providing for adequate financial cushions.

Conclusion

BCBSA remains opposed to provider initiatives to exempt PSOs from current Medicare risk contractor that standards require compliance with state licensure and consumer protection rules. Under current Medicare rules, federal law provides a minimum set of consumer protection standards with which all Medicare risk contractors must comply. This provides a national "floor" for consumer protection. Medicare law also requires Medicare risk contractors to comply with state consumer protection rules so that beneficiaries have access to the strongest protection standards available. We believe Medicare beneficiaries deserve the protection of both federal and state consumer rules and that all Medicare risk contractors should compete on a level playing field.

Mr. BILIRAKIS. Thank you.

Let's switch to Dr. Margolis at this point.

STATEMENT OF ROBERT MARGOLIS

Mr. MARGOLIS. Thank you very much, Mr. Chairman and members of the committee.

My name is Robert Margolis. I'm an internist and cancer specialist, been practicing in Southern California for some 23 years. I also serve as the chief executive of Health Care Partners Medical Group, which is the largest managed care physician-owned organization in California. We serve over a quarter of a million capitated managed care members, as well as 40,000 Medicare risk members, and we've been doing so since 1985 under both shared and full risk programs.

I'm here today also representing the American Medical Group Association, which serves approximately half of our managed care members in the country, through its members, 1 out of every 10 Americans.

This PSO debate is extremely important and one that I'm pleased to have a chance to participate in. It does, however, remind me a bit of the economic theory debate, that PSOs are being debated to see whether they will work, in theory, when they have been working, essentially, in practice, for many, many years. I think there is a lot of evidence to support that.

A.M.G.A. supports this move toward PSOs for a variety of reasons. Let me characterize a few of them. Doctors are in the practice of medicine, and health plans aren't. There is a defined and dis-

tinct difference between the two. I think that the debate today has been very critical around issues of solvency and quality assurance, and I'd like, during this discussion, perhaps during questions, to try to differentiate those two very specific issues.

The debate can be and continues to be about how do we move health care and health care decisions back to the doctor-patient interface? Where a doctor and patient or family are making decisions, we will have the highest likelihood of creating both the best potential value for the patient, cost, and quality at the same time.

Quality care is the accountability of the providers, not the health plan, and quality care needs to be measured and monitored at the provider level, through the kinds of systems that are proposed in this bill, and we can talk more about that. They are providers of care and in the best position to coordinate the care and the delivery, and to remove the issue of third parties in the decisionmaking regarding health care decisions between patients and their doctors. This bill helps to provide that.

This bill also promotes the continued integration and consolidation of the health care system, which is creating the efficiencies and helping to capitalize the infrastructure necessary to do the important things we're doing.

This bill will also expand choice and competition. It will promote quality systems and integration. And it will promote, I think even more importantly, enhanced consumer information flow, in that consumers, Medicare consumers, are going to need to be able, based on the information, choose the system that will best give them the quality that they so justly deserve.

And the system will reduce costs, since we know that, over time, a direct relationship between a vendor of services, the providers, and purchaser of services, the government in this case, will eventually create the kinds of systems that reduce costs.

We support the fact that this bill removes the 50/50 rule. I think there was a question to the earlier panel regarding that. I believe that most of the health plans also find very little evidence that the 50/50 rule is a protector of quality.

We support the fact that the solvency requirements are extremely critical, and support, in general, the NAIC's panel that was here and the solvency requirements that the NAIC has suggested, adjusted to take into account the fact that there are quantifiable differences between providers of care, and the risks they bear, and insurers of care.

While there was specific truth to the issue that the regulators spoke of, the issue of being an insurer, and those risks and how they need to be regulated, there are distinct and definable differences between providers of care and insurers of care.

We especially support the Federal uniform licensure requirements. Medicare is a Federal program; it should be uniformly offered to Medicare beneficiaries across the country.

So if, in actuality, this committee, in its wisdom, and Congress, in its wisdom, sees that we can create a single Federal standard protecting consumers with the consumer protections that are in this bill, with the solvency protections that have been suggested by the States and the State commissioners—and let me, as an aside, suggest that the NAIC, which gave some fairly compelling testi-

mony, has been trying for many, many years, to their credit, to get some kind of consistency among the States on State regulations, on solvency requirements, on quality requirements.

They have not been able to get the States to adopt any kind of uniformity. So there is an enormous difference among States on the kinds of regulations.

So the opportunity to introduce an important new aspect of choice to Medicare through this type of bill, with Federal exemption for a period of time, to get it going, is not too dissimilar from the efforts that Congress took in 1973 to start the HMO industry going. I think that, with appropriate solvency and consumer protection requirements, and the quality enhancement aspects that allow the 50/50 rule to be waived, this is a bill in the right time, at the right place, and we support it.

[The prepared statement of Robert Margolis follows:]

PREPARED STATEMENT OF ROBERT MARGOLIS, AMERICAN MEDICAL GROUP ASSOCIATION

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Dr. Robert Margolis, chairman of the American Medical Group Association, and Managing Partner of Health Care Partners a 330 physician multi-specialty group practice which provides care to more than 250,000 commercial patients, 40,000 Medicare beneficiaries in both capitated and fee-for service reimbursement modalities at 30 sites throughout the Los Angeles area. I am board-certified in internal medicine and medical oncology with a medical degree from Duke University. I appreciate the opportunity to testify before the committee today.

Both predecessor organizations which merged to create the American Medical Group Association supported Provider Sponsored Organization (PSO) legislative proposals during the last session of Congress. Formed by the 1996 merger of the American Group Practice Association and the Unified Medical Group Association, AMGA now represents over 200 of the nation's most innovative and prestigious medical groups and more than 40,000 physicians practicing in those groups.

Our membership includes many of the most highly-respected multi-specialty medical groups in the country, including the Watson Clinic, the Mayo Clinic, the Marshfield Clinic, the Dean Health Center, the Portland Clinic, the Oklahoma City Clinic, the Lewis Gale Clinic, the Lexington Clinic, the Scott and White Clinic, the Cleveland Clinic, The Henry Ford Health System, Scripps Clinic Medical Group, Permanente Medical Groups, MedPartners-Mullikin, HealthCare Partners and many others. *All of AMGA's members are governed and managed by physicians: a factor that we believe is essential to the successful delivery of high-quality, cost-effective health care.*

AMGA is dedicated to the advancement of these integrated health care delivery systems, and we are eager to work with the Committee and the nation's leaders to find equitable solutions to increase Americans' access to the highest quality, affordable health care.

I want to commend the Committee for taking up this issue so early in the session. The debate regarding Provider Sponsored Organizations (PSOs) will be contentious, because the issues involved are crucial to competition for patients by all of the special interests involved in the debate. Please bear in mind that quality of care for patients, the accountability of systems for the care provided, and the impartiality of relationships between medical care systems and our insurance partners are critical to a fair market.

I am here today to offer support for this proposal. We believe the proposal holds promise for higher quality, coordinated care for Medicare beneficiaries. We believe that an expanded range of health care delivery options in Medicare markets will lead to measurable savings in the Medicare program. We believe that a Provider Sponsored Organization option will be a valuable and popular addition to the current range of options available to Medicare and Medicaid beneficiaries. In fact some of our members believe that such a Medicare option will be so attractive to high-risk patients that our members are reluctant to enter this market until Medicare has developed a fair mechanism for risk adjustment. Others, on the other hand, will

not compete in (primarily rural) risk markets until HCFA can assure an adequate and stable reimbursement rate.

We believe that physician leadership is critical in any high-quality health care delivery system. If non-medical managers who answer to a board of directors, or business executives who answer to shareholders, are in a position to set health care policies or make health care decisions, quality will give way to cost.

A Provider Sponsored Organization option will not be a panacea, but it will be an added dimension, that will increase competition in the medical marketplace, and it will help focus patients' attention on delivery of care processes. It may well be an antidote to some of the poison of financial intervention in clinical decision-making.

Patient care, despite all the talk about health plans and traditional insurers, is the responsibility of physicians and other individuals providing care under their supervision. Physicians are professionally accountable for the care their patients receive. HMOs do not deliver health care; doctors do. Insurance companies do not practice medicine; physicians do. Medical decisions are made by physicians in consultation with the patient and other health care providers as appropriate. Because of this, the doctor-patient relationship is critical, and the integrity of this relationship must be preserved.

Federal legislation and regulation must assure that quality of care and accountability for health care services resides with physicians and not with health plans, insurance companies or HMOs.

We are concerned about the long-term effect insolvencies might have on the medical marketplace. Consequently we are pleased that the authors of the bill have been appropriately conservative in the requirements set forth to protect consumers.

Mr. Greenwood, we appreciate the leadership you and Representative Stenholm, as well as Senators Frist and Rockefeller have provided in initiating this debate. We look forward to the opportunity to support your efforts to improve care for Medicare beneficiaries.

THE MEDICARE PROVIDER-SPONSORED ORGANIZATION ACT OF 1997

AMGA supports legislation which would allow "provider-sponsored organizations" (PSOs) to contract directly with HCFA to deliver medical services to Medicare beneficiaries.

Under current law, Medicare beneficiaries can choose to receive their care under a traditional fee for service arrangement or from an HMO. The bill would create a third option aimed at keeping health care decisions in the hands of the provider and the patient. Under this bill, there would be a four year window from 1998 to 2002, when PSOs would be certified to provide benefits to Medicare beneficiaries at the federal level. Medicare contracts with PSOs would not require, and states would be preempted from requiring, state HMO or insurance carrier licenses for at least the first four years.

The authors of the bill believe that state insurance licenses should not be necessary for Medicare to enter into service contracts with health providers. The lengthy process for obtaining HMO licenses would slow Medicare movement into coordinated care.

A "qualified" PSO would be paid on a capitated prospective basis. To be considered as qualified, a PSO must provide a substantial proportion (as defined by HHS) of the health care items and services under the contract directly through the provider or through an affiliated group of providers that comprise the organization. Affiliated providers are those that share a significant common economic interest through common control or ownership, or who share substantial risk. The bill suggests that a "substantial proportion" means significantly more than a majority of contracted services, with most of the remaining services covered by written agreements that protect consumers.

Standards

PSOs would fall under the same standards and contracting arrangements that now apply to Medicare risk contractors, HMOs, and CMPs, but with a limited number of changes crafted to eliminate barriers to PSOs while maintaining consumer protection and emphasizing quality assurance.

The bill would waive the 50/50 rule for any risk contractor that met new, enhanced quality requirements. The 50/50 rule currently states that a health plan's Medicare and Medicaid enrollees cannot exceed 50 percent of its total enrollment. The rationale behind the rule is that if a plan has more than half of its enrollees from the private sector, it will maintain a high quality of care, compared with an enrollment base mainly comprised of Medicare or Medicaid beneficiaries. Waiver of

this requirement is especially necessary for risk contractors in rural areas to serve the disproportionate share of elderly in these areas. Therefore, the minimum enrollment levels would be changed for all contractors from 5,000 to 1,500 and from 1,500 to 500 for risk contractors serving rural areas.

Under the proposal, the current Medicare requirement that a plan's enrolled population include at least 50 percent commercial enrollees (the 50/50 rule) would be waived for any risk contractor that met the following requirements. The PSO must have an ongoing quality assurance program that A) stresses health outcomes; B) provides opportunities for input by physicians and other health professionals; C) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; D) evaluates the continuity and coordination of care that enrollees receive; E) establishes mechanisms to detect both the underutilization and overutilization of services; F) after identifying areas for improvement, establishes or alters practice parameters; G) takes action to improve quality and assess the effectiveness of such action through systematic followup; H) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options; and I) is evaluated on an ongoing basis as to effectiveness.

If the PSO utilizes case-by-case utilization review in its quality assurance program the PSO must base its UR on written protocols developed on the basis of current standards of medical practice. The PSO must also implement a plan to coordinate UR with the quality assurance program, phasing out case-by-case review, and transition to methodologies which focus on patterns of care.

The bill also establishes fiscal soundness and solvency standards that must be met for a PSO to be federally qualified. The bill specifies explicit as well as general measures for fiscal soundness which reflect current HMO and insurance regulatory practices, modified to recognize the different operational characteristics of qualified PSOs.

The authors of the legislation believe that PSOs are not insurance companies. Their primary business is the delivery of care, not the pooling and spreading of risk. The core business of integrated delivery systems which could qualify as a PSO is health care delivery, rather than insurance, and the assets of such organizations are used predominantly to deliver care to patients under a variety of payment methods including but not necessarily limited to capitated risk payments from Medicare.

Under the bill the fiscal soundness of such organizations may be demonstrated either by meeting specific net worth and reserve requirements or through reliance on a combination of factors which ensure an adequate cushion against unexpected events. For the purpose of demonstrating the net worth of a PSO, the value of land, buildings, and equipment, and receivables from governmental programs due for more than 90 days would be admitted as assets of the organization.

For the purpose of demonstrating the solvency of a PSO, a variety of alternative measures in common practice within the insurance industry may be employed. Letters of credit, financial guarantees, reinsurance and stop loss insurance, actuarial certifications, unrestricted fund balances, the presence of non-risk related revenue and diversity of lines of business will all be taken into consideration by the Secretary of HHS in licensing a PSO to accept Medicare risk.

The Advantage of Medical Group Organizations

The Committee is well aware of the revolutionary changes sweeping health care financing and delivery in the United States. AMGA urges the committee to carefully examine the financing, organizational structure and delivery of health services by integrated, medical group practices. We believe that these systems are playing and will continue to play a distinct and vital role in the American health care system.

Clearly, the increased emphasis on the costs and quality of medical care has created the need for better management and more organization in the delivery of health care services. For many years, integrated, medical group practices have recognized that in delivering health care, cost and quality are inseparable. As a result, these systems have evolved and will continue to evolve into highly-sophisticated systems in which patient care is managed for the best outcomes by emphasizing the value of teamwork—an interdisciplinary approach to patient care that focuses on improving the functional status, quality of life and the health of patients.

In fact, the success of integrated group practices can be attributed in large part to their shared mission and their unique culture. They share a commitment to coordinated health care by providers concerned about prevention, education and management of chronic conditions, as well as the treatment of acute conditions. This commitment has been at the heart of the group practice movement for several decades. As a result, group practice patients benefit from quality care management fos-

tered by an organized system of delivering care that encourages peer review, cross training, professional development, and constant measurement of results.

Many group practices and integrated delivery systems form the core of a managed care organization's delivery system, accepting full or partial capitation for the care of patients, while others own and operate health plans and are fully state licensed. These organizations are prepared to enter the PSO market and compete head to head with other Medicare risk contractors.

Whether they will or not is yet to be seen. In some markets, it would be suicidal for a fully integrated system to compete with its best partner in business, the managed care organization or the predominant insurer in the community. In other markets, the sledgehammer management styles of insurers has turned existing integrated systems into sweatshops, and the physician and provider community is seriously considering unionizing to offset short-term bottom line management decisions which are compromising both physicians and patients. In these and other markets the mere availability of the PSO options will alter the balance between contract negotiations, resulting in more favorable terms for the physicians and providers who deliver care. We believe this shift in the negotiating strength will result in lower costs, better access to high quality care and enhanced focus on issues related to clinical quality improvement.

A Commitment to Quality

Provider-sponsored organizations should be held to high standards that ensure consumer protection and quality assurance. But much can be said about quality without ever addressing it. The President is still considering the appointment of a managed care/quality commission. Congress recently enacted maternity length of stay legislation, which for the first time ever, tells doctors how to treat their patients. And there are indications that this is only the tip of the legislative iceberg, with signs that we shall see, in the 105th Congress, gag-clause legislation, mastectomy length of stay bills, anti-managed care legislation, and an avalanche of proposals drafted to protect disenfranchised providers, and obsolete technologies. It is a slippery slope and one we hope that the Congress will be reluctant to scale. AMGA understands the good intentions which motivate these and other bills, but they interfere with medical judgment, and the appropriate allocation of resources to assure the highest quality of care for the greatest number of beneficiaries. Mandates sidetrack resources that can more effectively be applied to treatment and prevention of avoidable disease.

AMGA would like to remind the Committee of that which you already know: That true quality in patient care cannot be mandated by any regulatory body. It can only be realized when health systems are structured in such a way that incentives support doing what is best for the patient.

The recent flurry of legislation and regulation related to the perceived abuses of managed care does little if anything to ameliorate health care quality problems. At best, they may have an indirect effect, caused by the overall perception that health care is being scrutinized more carefully. At worst they are entirely irrelevant and obstructive to quality improvement. The task of improving the quality of care which patients receive requires a systematic and concerted effort that is resource, time and capital intense.

AMGA's members have long been at the forefront in the pursuit of clinical quality improvement. For many years, they have realized that quality management and outcomes research must serve as the cornerstones of quality medical care. For our members, outcomes measurement and research provides a scientific basis for patient care management. In fact, the group practice setting is ideal for large-scale outcomes measurement and the application of continuous quality improvement because care tends to be delivered in a comprehensive manner to large and stable populations.

Many AMGA members use their outcomes findings to define the best care management practices and protocols, which can be further developed and tested within the groups. In fact, as organized systems of care, our groups have developed complex and technologically advanced information systems that enable them to constantly evaluate practice patterns to make continuous improvements. This work leads to better treatments and outcomes for patients, and as a result, cost savings.

AMGA physicians have found that quality outcomes measurements go a long way towards assuaging the fears of our patients. There are populations within our health care system that are vulnerable and need to be followed more carefully. For a number of years, AMGA's medical groups have been tracking potentially vulnerable groups of patients to assure that sufficient attention is paid to undiagnosed health conditions and prevention.

For example, we have learned that 33% of patients with diabetes screen positive for risk of depression. The data also show that those who screen positive for depression have significantly lower average scores on all diabetic functioning scores than patients screening negative for depression. Armed with this information, clinicians treating patients with diabetes can direct services toward diagnosing and treating all underlying symptoms in addition to the diabetes itself.

None of this is rocket science, but there is a great deal of medical learning that is yet to take place. Outcomes research is in its infancy and can only be put in place by organizations that can aggregate data from a wide variety of sources within the organization. Integrated delivery systems and provider sponsored organizations are some of the few entities that have the existing resources and the clinical management to engage in this essential research.

Consumer Protection and Solvency

One of AMGA's primary concerns in its consideration of the Greenwood/Stenholm PSO bill relates to the problematic area of assuring that new organizations licensed to provide Medicare services do not compromise the future of market reforms by failing to adequately protect Medicare beneficiaries. We are pleased to see that the standards are even more detailed and explicit than current Medicare law relating to quality and solvency for HMOs. Beneficiaries will be protected from incurring any financial liability if a PSO became insolvent.

AMGA supports the concepts recently announced by the Physician Payment Review Commission that would apply the same core standards to all private health plans participating in the Medicare program, with flexibility to develop and enforce such standards. In recognizing the legitimate differences between provider-sponsored organizations (PSOs) and insurance companies, we strongly believe that PSOs should be held to equivalent, but not necessarily identical, solvency standards as insurers.

PSOs that are financially and clinically integrated represent the best models capable of providing care for a comprehensive Medicare benefit package while assuming financial risk for those services. The entry of qualified PSOs into Medicare markets will complement the existing menu of health care services, and challenge all other organizations to lower costs, improve care, and preserve relationships between patients and those individuals who provide their care.

Competition

Medicare is one of the fastest growing segments of the managed care markets. Competition for Medicare enrollees has increased further with the expansion of the Medicare Select program, and the addition of other new Medicare options.

The market is expected to grow even more competitive in the near future if Congress permits providers to go directly at risk for Medicare patients as participants in provider-sponsored organizations.

AMGA's experience has been that as seniors become more aware of the coverage afforded through most HMOs, the attractiveness of an HMO option increases. Patients are attracted to the Medicare managed care concept because of the idea that they have "one stop shopping." That is, one medical group provides all of their health care services—often in one location. This is a core strength of certifiable PSOs and integrated systems of care. AMGA member organizations are made up of physicians—of many specialties—who practice together, believing that this is the best way to provide care. Our group practice philosophy naturally complements the desire of patients to have health care provided—as much as possible—in one location.

AMGA would like to emphasize that our members define managed care first and foremost as the management of actual patient care or *care management* in order to provide the most appropriate, high-quality cost-effective care. To AMGA medical groups, managed care can not be defined as simply the management of dollars.

In fact, AMGA represents systems that have adopted a variety of different payment mechanisms, including both fee-for-service and capitation. And in fact, the group practice mode of delivering health care existed long before the cost containment pressures of the past two decades. A commitment to coordinated health care has been at the heart of the group practice movement for several decades. Even in a fee-for-service context dominated by indemnity style insurance, group practices have embraced delivery systems of coordinated providers that manage patient care using a multispecialty model.

Within AMGA, this shared view of the best way to care for patients is the common ground where group practices that have operated largely in a fee-for-service context have come together with prepaid group practices. Managed care techniques, including utilization review, quality improvement programs, case management,

capitated reimbursement of physician groups, reliance on primary care and exclusive networks of carefully selected, integrated providers, have been integral to many medical group practices long before managed care spread because of cost pressures.

AMGA medical groups see on an almost daily basis that seniors usually live on fixed incomes. For this reason, "cost" is another factor that AMGA would ask the Committee to keep in mind. Medicare managed care can be provided to beneficiaries in such a way that saves beneficiaries' financial resources. According to HCFA, nearly two-thirds of all Medicare managed care plans currently offer a zero premium product. This is a 40 percent increase in the last five years.

But it is interesting that zero-premium plans have sometimes raised concerns among seniors. Many of our medical groups have found that our physicians must spend considerable time educating beneficiaries who do not understand how a plan can deliver good health care without charging some kind of premium. This is especially true in areas with little or no experience in managed care. We know these concerns are unfounded. As more and more Medicare beneficiaries recognize the comprehensive quality and value of health care services provided through integrated delivery systems we expect to attract large volumes of patients.

Risk Adjustment

Payments to Medicare managed care plans should be risk adjusted to take into account the higher costs of treating people with chronic and more expensive health problems. Plans with a demonstrably higher share of beneficiaries with expensive chronic diseases should be paid more. The Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Without better risk adjustment, medical groups with excellent programs for patients with chronic diseases may be reluctant to offer their own Medicare health plans for fear of adverse risk selection.

Conclusion

In closing, AMGA believes that Medicare patients have unique needs and characteristics. AMGA medical groups have designed Medicare managed care plans with these needs in mind. The needs of the Medicare population require a coordinated care approach—which multi-specialty group practices are perfectly situated to deliver. The organizations we represent look forward to the opportunity to make the finest medical services widely available and affordable.

AMERICAN MEDICAL GROUP ASSOCIATION
ALEXANDRIA, VA
March 17, 1997

The Honorable MICHAEL BILIRAKIS
Chairman, Subcommittee on Health and Environment
Committee on Commerce
Washington, DC

DEAR CHAIRMAN BILIRAKIS: For the purposes of disclosure required by "Truth in Testimony" Rules of the House, please be advised that the American Medical Group Association has not received any Federal grants or contracts during the current fiscal year or either of the two preceding fiscal years.

Sincerely,

DONALD W. FISHER, PH.D., CAE
Chief Executive Officer

Mr. BILIRAKIS. Thank you. Thank you very much, Doctor.

Mr. McMeekin.

STATEMENT OF JOHN C. McMEEKIN

Mr. MCMEEKIN. Thank you, Mr. Chairman.

My name is John McMeekin. I'm president and chief executive officer of Crozer-Keystone Health System, which is a network just outside of Philadelphia. I also have the privilege and pleasure of serving as a member of the board of the American Hospital Association, and I'm here today to talk on behalf of our 5,000 AHA members: hospitals, health systems, a variety of health providers, all of whom are committed to providing Medicare beneficiaries this additional provider-sponsored choice.

Crozer-Keystone Health System is one of the nine Health Care Financing Administration demonstration sites under the Medicare choices program. We have just begun to launch our plan, called "MedCare Plus." In the several weeks that we have been in our marketplace, 50 Medicare beneficiaries per week have enrolled. Our best sense of why we've had that rapid and immediate response is the fact that we are the providers, the hospitals and the doctors, that those 95,000 Medicare beneficiaries in our county have come to know over a long number of years.

We established this program and applied for the demonstration because we really felt that there was an opportunity to consolidate and concentrate both the capacity and interest of providers, and the clear interest of our seniors, in building a healthier community and a healthier lifestyle for those seniors.

We believe that our program will emphasize wellness and prevention, not just for seniors, but for the entire community that they are part of. In a word, I guess we think of provider-sponsored organizations, or PSOs, as focusing on community and managing care, not just the cost of care. Managing care is really the traditional business of providers.

I understand there is some confusion about PSOs and what we are trying to accomplish with them. In my detailed statement for the record, I hope many of those points were raised and answered, but I'd like to concentrate on just four points in my verbal comments today.

First, PSOs and the enabling legislation introduced by Mr. Greenwood and Mr. Stenholm focus on Medicare only. Others will argue that PSOs are already being accommodated in the private sector and that State insurance commissioners are adequately addressing PSO concerns. But the debate in Washington is not about the commercial market; that is not our interest. The debate and the legislation focus exclusively on creating Medicare-qualified PSOs and on opening an opportunity for PSOs to deliver to Medicare beneficiaries a new option.

Organizations like mine believe that we have something to offer seniors in our community, and we believe seniors and the Medicare program will both benefit from this additional option. But PSOs cannot become an option for seniors without a change in legislation. We need your help in creating that opportunity.

Second, the primary goal of PSOs is to expand the care choices available to our seniors. PSOs will almost certainly not be the only new choice. As health care continues to change as rapidly as it has, I am certain we will see additional new and exciting models.

Frankly, we don't understand why anyone would object to offering additional choices to seniors, assuming, of course, that appropriate consumer, clinical, and solvency safeguards are put in place, which we believe to be the case with H.R. 475. The bottom line is that the Medicare program should provide seniors with as much health plan choice as possible.

My third point is that it has been suggested that PSOs would not have to meet stringent solvency standards. That's simply false. Hospitals want PSOs to be governed by the kind of standards that will help ensure that they are long-term Medicare options in our communities. We have no interest to see them undercapitalized,

poorly managed, and becoming a problem for our seniors. That would not be in anyone's best interest, certainly not those of a provider.

In terms of solvency, H.R. 475 specifies that PSOs would meet solvency standards similar to those in the Federal HMO Act, along with additional standards drawn from the National Association of Insurance Commissioners' Model HMO Act, upon which 29 States now pattern their legislation. In essence, proposed PSO solvency standards are similar to those applied to HMOs in many States and, in some instances, more stringent than those required at the State level.

We propose that PSOs meet the same net worth, same reserve requirements as HMOs. The bottom line is solvency standards that will be available to judge PSOs, similar to those used to judge HMOs today. We believe those standards should be set at the Federal level, which is appropriate for Federal programs.

Mr. BILIRAKIS. Please summarize, sir.

Mr. MCMEEKIN. Finally, most important, PSOs seek to deliver high-quality care. We propose that PSOs, no one else, be required to meet even higher state-of-the-art quality standards that offer Medicare risk contractors a chance to show the new opportunities in quality assurance.

Mr. Chairman, we would appreciate the opportunity to advance the debate on this Medicare option. We believe it is in the interest of our seniors, and we thank the committee for your efforts.

Thank you.

[The prepared statement of John C. McMeekin follows:]

PREPARED STATEMENT OF JOHN C. MCMEEKIN ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am President and CEO of Crozer-Keystone Health System in Media, Pennsylvania, just outside of Philadelphia. We are a comprehensive health system, offering health promotion services, primary and specialty physician care, hospital services, and home health, long-term and hospice care.

We are one of nine HCFA-approved provider-sponsored Medicare Choices demonstration projects. We have just launched our new "MedCare Plus" point-of-service offering to deliver coordinated services to Medicare beneficiaries; our target is to enroll 4,000 seniors in the first year. In the first two weeks we have signed up 200 beneficiaries. We're proud of what we're now able to offer beneficiaries, including no additional premium—meaning no need for them to buy a supplemental "Medigap" policy—and only a modest copay and deductible to receive services out of our network. We reward healthy behavior—for example, by giving extra benefits for exercising regularly. We believe we can provide superior service by having roughly three times the number of service representatives compared to others in the field. And, from a clinical perspective, our own physicians oversee utilization management, not outside reviewers. On behalf of the American Hospital Association and its 5,000 hospitals, health systems, and other providers of care, I welcome this opportunity to testify on provider-sponsored organizations, or PSOs.

Toward a more integrated health care market

Marketplace and regulatory pressures are rapidly reshaping health care delivery into "integrated" systems of care. Provider-sponsored organizations—such as Crozer-Keystone's MedCare Plus program—are one emerging form of increased delivery system coordination. PSOs can help with the critical task of balancing health care resources with growing needs—particularly important in caring for the elderly as the baby boomers begin to retire—all within the context of a community and its overall health. Consequently, we are pleased to testify in support of PSOs and their potential value to the Medicare program. And, we commend Rep. Jim Greenwood (R-PA) for introducing—along with Rep. Charles Stenholm (D-TX) —H.R. 475, legislation we wholeheartedly endorse, that would add PSOs to the options available to Medicare beneficiaries.

Today, we would like to explain what PSOs are, and outline the critical elements embodied in H.R. 475 that we believe must be part of any Medicare PSO legislation.

PSOs come in many shapes. Integration among hospitals, physicians, and other caregivers is a prime characteristic of PSOs. The integration can take many forms, among them: consolidating administrative activities; jointly sharing payment risk; coordinating clinical care; and combining or merging corporate and governance structures. PSOs accomplish this integration through various organizational structures, and have the ability to accept financial risk-sharing for a broad spectrum of services in their contracts with health plans, including under capitated payment (a fixed, per-person, per-month payment). Consequently, PSOs can make a major contribution to the evolution in how managed care is practiced in this country. As community-based, integrated networks of providers that offer a spectrum of care in exchange for a fixed payment, PSOs can achieve both *cost* and *quality* goals:

- *PSOs achieve the cost efficiencies necessary to hold down health care costs* by *directly managing* both the *use* of services *and the cost of producing those services.* PSO direct contracting relationships have the potential to decrease the overall costs of health care by reducing one layer of billing and administrative processes injected by insurance companies and many HMOs. Such direct contracting preserves the largest percentage of health premiums or government health expenditures for direct patient care and community health improvement initiatives.
- *Since PSOs are provider-driven, not insurer-driven, they put clinical decisions in the hands of those most capable of balancing efficiency and patient care*—local community-based health care providers.
- *PSOs address consumer concerns about stable relationships with providers.* Under some commercial managed care plans, panels of participating clinicians change frequently as the plans move from one provider group to another, seeking deeper discounts. PSOs are built on a more stable provider base—often the very providers with whom consumers already have established relationships. Consumers don't have to change plans to follow their providers; their providers are the plan.
- *PSOs are good for local communities.* Rooted in communities, PSOs are attentive to the long-term interests of the communities they serve. They are more likely, for example, to focus on improving the health of the entire community.

Essential Elements of a Medicare PSO Option

More important, PSOs can provide both cost savings and quality to Medicare beneficiaries as well. PSOs carry benefits beyond those normally associated with a managed care plan—such as the ability to choose physicians and hospitals, not just a plan and whichever providers come with it. We're the hospitals and doctors our seniors know. Because PSOs help maintain the direct link between patients and providers that Medicare beneficiaries often cite as the most important aspect of their care (and also cite as a major reason for staying with traditional fee-for-service Medicare), we believe these benefits will motivate Medicare beneficiaries to choose PSOs.

But in order to assure that PSOs are a viable option for seniors, Medicare should enter into contracts only with PSOs that provide coordinated care, accept financial risk-sharing, and meet Medicare's risk contracting requirements. While the basic definition of a PSO is a public or private provider or group of affiliated providers organized to deliver a spectrum of health care services under contract to purchasers of such services, *Medicare-qualified PSOs* should be even more precisely defined, as they are in H.R. 475. Important criteria, included in the bill, are as follows:

First, Medicare-qualified PSOs must provide the entire Medicare benefit package to seniors. In addition, they must deliver the *substantial portion* of those services—significantly more than half—directly through their own affiliated providers. Most of the remaining services must be delivered by providers who are under contract to the PSO. This allows health care providers to come together to form a delivery system through a variety of means, including common ownership, common control, or substantial shared financial risk. It also ensures sufficient integration to support true coordinated care and capitation.

Second, all Medicare health plan options should ensure that beneficiaries are protected from poor quality care, financial liability from poorly managed plans, and inappropriate plan behavior. To that end, H.R. 475 would require that all PSOs be subject to federal Medicare requirements imposed on Medicare risk contractors regarding marketing practices, enrollment processes, enrollee rights to review of coverage decisions, appeal mechanisms that involve external reviewers, and disclosure of plan information.

Third, H.R. 475 proposes to enhance quality assurance standards and make solvency standards more appropriate to PSOs. The revisions we support are, in many cases, applied only to PSOs, based on distinctive PSO characteristics; others apply to all Medicare risk contractors. These include the following:

Waive the 50/50 requirement in favor of direct measurement of quality and coordinated care experience. The requirement that Medicare risk contractors have at least 50 percent commercial enrollment (the "50/50 rule") is a significant barrier to PSO Medicare contracting. It doesn't recognize the experience PSOs gain as they contract to provide patient care services to managed care organizations because of their "down stream" care giver position.

Medicare-qualified PSOs would not enter the commercial market to sell health plan coverage. Rather, they would maintain their traditional direct relationships with Medicare by using their coordinated care experience gained under managed care contracts to provide coordinated care to beneficiaries under a Medicare health plan contract.

As in H.R. 475, we believe all Medicare risk contractors, including PSOs, should be able to have the 50/50 rule waived *if* they meet enhanced quality assurance requirements and can demonstrate experience in providing coordinated care (as a health plan or, more likely, under contract with health plans). Waiver of the rule would acknowledge that its original purpose as a proxy for quality measurement is no longer necessary, given today's improved quality measurement tools.

A federal certification process should be provided initially for PSOs, with involvement of state regulators appropriate to a Medicare-only plan. It is inappropriate to initially require both federal certification *and* state licensure for PSOs when PSOs are directly enrolling only Medicare beneficiaries. Medicare already has its own rules on contractor capabilities and consumer protections, and the vast majority of these rules would apply to PSOs without change.

From a government efficiency perspective, it does not make sense to initially require state licensure. The state's findings are of little use to Medicare in judging whether PSOs meet federal requirements; Medicare must do its own evaluation, under its own rules, of the PSO. If the PSO is not directly enrolling individuals in the commercial market, a state licensure process is inappropriate and not needed on top of federal Medicare requirements. .

We support H.R. 475's reliance on an initial four-year period of federal rules and federal certification to enroll Medicare beneficiaries. During that time, Medicare could contract with state agencies to locally monitor on-going PSO performance. After the first four years, Medicare could then allow state licensure in those states where their requirements are identical to the federal standards for solvency, and generally line up with federal requirements for quality.

Adopt a PSO solvency standard that is responsible and specific. In the 1995-96 Congressional debate about how to include a PSO option, the Congressional proposals included a process for the Secretary to develop solvency standards, without the inclusion of any specific statutory requirements. Unfortunately, the lack of a specific standard created the inaccurate impression that hospitals and physicians did not support appropriate solvency requirements, and raised significant concerns.

Let us assure you at the outset that the American Hospital Association supports a rigorous and specific standard, like the one included in H.R. 475. We, like you, do not want to encourage undercapitalized PSOs to contract with Medicare. Specifically, we recommend that the current Medicare HMO/CMP requirements for financial soundness, insolvency plans, provider contracting, and continuity of care and coverage be applied to PSOs as well. This ensures that both Medicare beneficiaries and the Medicare program will be equally protected under PSO contracts, as they are under HMO and CMP contracts.

Further, we recommend that the PSO financial soundness test be specified in the Medicare law. We believe the financial soundness test should be based on the net worth and reserve requirements found in the National Association of Insurance Commissioners' (NAIC) current model HMO act.

Basing the federal standard on NAIC's model, as H.R. 475 specifies, does also require limited revisions to reflect accounting differences and payment variations between PSOs and HMOs, and to assure that the model act's recognition of health delivery assets in assessing net worth is maintained. This last issue is especially important to PSOs because it recognizes that their core business is the delivery of health care services—not selling insurance. This recognition acknowledges that PSOs meet their coverage commitments primarily through using their assets to produce the covered services directly, rather than selling investment assets to pay claims. The presence of a claims reserve requirement ensures the PSO has the capacity to pay for services they do not produce directly, such as out-of-area services.

We also recommend that alternative means of demonstrating financial soundness be recognized, such as letters of credit, financial guarantees, reinsurance or stop loss insurance, certification by an independent actuary, unrestricted fund balances, diversity of lines of business, and presence of non-risk related revenue. These alternatives include items found in many, but not all, state statutes or regulations, and many of the alternatives are practices common within the insurance industry.

Medicare should take advantage of the unique capabilities of PSO health care delivery systems to consistently implement high-level quality requirements that reflect the state-of-the art in quality management and also address problems with some current forms of managed care. There are many problems with some current forms of managed care that health care providers see every day, such as the degree of intrusion in the doctor-patient relationship caused by health plan cost management techniques, the degree to which clinical management policies are not developed by practicing clinicians, and the degree to which cost considerations seem to override quality considerations. PSOs provide a way for hospitals and physicians to develop and implement their own approaches to addressing these problems.

PSOs would develop and implement plans to move from utilization review done on a case-by-case basis as part of a precertification or claims review process, to the evaluation of patterns of care as part of an integrated quality assurance and utilization management process. This will develop the mechanisms that are most effective in evaluating and altering inappropriate care patterns, while putting clinicians back in charge on a day-to-day, patient-by-patient basis.

PSOs participating in Medicare should be eligible for full-risk and partial-risk payments. Currently, Medicare full-risk plans are paid on the basis of 95 percent of the Adjusted Average Per Capita Cost, or the AAPCC. That system itself, however, is seriously deficient in several ways and in need of reform.

There is wide variation in historic fee-for-service utilization patterns, and therefore a resulting wide variation in health plan payments—*more than 300 percent among counties across the United States.* We believe these payments should be made more equitable across the United States in a way that will allow more communities to establish provider-sponsored networks.

We advocate Medicare managed care payments that are uniform across the country, but then adjusted to reflect differences in the cost of delivering care due to the fact that some areas may care for less-healthy, more costly Medicare beneficiaries. The current AAPCC should be blended with a new payment rate that eliminates differences in historical patterns of use across counties. And, a payment floor should be quickly established to raise payments in the lowest-rate areas.

Finally, we believe that payments for graduate medical education (GME) and for those hospitals treating a large volume of low-income individuals—the disproportionate share hospitals (DSH)—should be "carved out" from Medicare managed care payments. The carve out is needed because traditionally the Medicare program has paid hospitals directly for the special, additional costs associated with teaching and with treating large numbers of low-income individuals. Because these special payments remain buried within a fixed, Medicare health plan payment, health plan organizations receiving the payment are not passing on the funding to those institutions actually incurring the added costs. Medicare payments for clinical education and for hospitals treating a disproportionately large share of low-income individuals should be paid directly to the organizations fulfilling those responsibilities.

In addition to AAPCC payment changes, we support a "partial risk" payment option for all Medicare plans, including PSOs. Where Medicare and a plan agree to partial risk payment, the plan would be responsible for offering the full Medicare benefit package, but would be paid a mix of capitation and cost for all services. Under such arrangements, the Medicare program shifts much, but not all, of its risk to the plan. This creates a more viable option in communities that have little or no access to such managed care options now. This provision allows participation by smaller risk contractors such as those in rural areas who may not be able to absorb the wide swings in costs that often occur in smaller pools of beneficiaries. It would also enable the greater use of coordinated care for the disabled and chronically ill.

We believe partial risk payment is critically important to efforts to expand the availability of coordinated care options under Medicare. Partial risk methods, already in use in the private sector to a significant degree, would increase the tools available to modernize Medicare.

Conclusion

We commend Rep. Greenwood and Rep. Stenholm for advancing the debate on PSOs—H.R. 475 includes the essential elements needed to create an important new option for Medicare beneficiaries. More importantly, their bill demonstrates that the

concerns raised last year by Members and interest groups were heard and have resulted in legislative improvements and refinements.

Mr. Chairman, we appreciate this opportunity to share with you our views on provider-sponsored organizations. AHA and its members are focusing significant resources on moving health care delivery to a more efficient and effective integrated model. We believe PSOs are the right vehicle to accomplish this goal. Powerful market, regulatory, and demographic forces undergird our view. AHA and its members believe that extending provider-sponsored organizations to Medicare would bring benefits to beneficiaries, to providers, to communities, and, perhaps most significantly from this Committee's point of view, to the Medicare program itself.

The AHA is deeply concerned about the impending Medicare financing crisis. Action must be taken soon to make fundamental structural changes that will allow this nation to continue to meet the health care needs of the elderly. Broadening beneficiaries' choice of Medicare health plans, including PSOs, is a vital part of this effort. Repairing the AAPCC's present variability and unpredictability should be another.

Overall, the Medicare program has been an outstanding success in bringing health care security to the elderly. In a nation where eroding access to health care coverage in the working population is already contributing to a steady rise in the uninsured, we cannot afford a future in which we lack the resources to keep the Medicare promise. We look forward to working with you to make provider-sponsored organizations a significant factor in a fiscally healthy Medicare program.

Mr. BILIRAKIS. Thank you, Mr. McMeekin.

Mr. Sobocinski.

STATEMENT OF THOMAS R. SOBOCINSKI

Mr. SOBOCINSKI. Thank you.

Mr. Chairman, members of the subcommittee, I am Thomas R. Sobocinski, president and CEO of Physicians Plus Insurance Corporation, in Madison, Wisconsin. Physicians Plus serves more than 100,000 members in south central and southeastern Wisconsin. The Physicians Plus network includes more than 2,000 physicians and more than 20 hospitals within that region.

Physicians Plus maintains a commitment to excellent customer satisfaction, high-quality, affordable health care for our members. In the March 1997 edition of Kiplinger's Personal Finance Magazine, it ranked Physicians Plus fifth in the Nation in HMO member satisfaction.

I am testifying today on behalf of the American Association of Health Plans, AAHP. AAHP represents approximately 1,000 health maintenance organizations, preferred provider organizations, and other network-based health plans, of which nearly 20 percent are provider-owned. I appreciate the opportunity to testify today about provider-sponsored organizations.

Physicians Plus was licensed as an HMO in 1987, and until May of last year was entirely owned and governed by providers. Physicians Plus Medical Group and Meriter Hospital comprised that ownership. Today, providers continue to hold two-thirds ownership and governance stake. We believe that Physicians Plus is an example of the right way for providers to take on health care risk.

By forming Physicians Plus HMO, the Physicians Plus Medical Group and Meriter Hospital entered the insurance business and became subject to the same licensing and financial solvency requirements applicable to any other HMO insurer in Wisconsin. We have encountered no unusual barriers in the licensing process.

In today's market, an increasing number of provider-owned entities like Physicians Plus are performing the same functions as HMOs and are in compliance with the same regulatory require-

ments. Physicians Plus has had a good, productive relationship with the Wisconsin Office of the Commissioner of Insurance. OCI makes little regulatory distinction between HMOs and other types of health plans. In fact, the four major HMOs operating in our immediate market are exclusively or partially owned by the provider community.

Wisconsin has had fairly high HMO penetration, consistently low health care premium costs, and very low rates of uninsured persons in our State. We think we're doing something right. And I'd like to make note that almost the complete lack of Medicare managed care in Wisconsin is primarily a direct result of the low payment rates. Not one of Wisconsin's 72 counties even reaches the national average of the AAPCC level.

Some want to urge Congress to pass legislation granting PSOs participating in the Medicare risk contracting program exceptions to the current law. While AAHP supports the expansion of choices for Medicare beneficiaries as a way to improve the current program, this expansion must be accompanied by safeguards for beneficiaries and the Medicare program itself, by ensuring that all Medicare offerings be consistent, national consumer protections.

In addition, AAHP believes that the entities performing the same functions, in this case providing health care to Medicare beneficiaries, should be required to meet the same standards. PSOs are growing rapidly in the marketplace under the existing State licensure and regulatory requirements for health plans. This growth makes it clear that, in contrast to the claims of PSO proponents, State and antitrust laws are not a barrier to market entry.

Physicians Plus stands as an example of a PSO that has succeeded in this environment for over 10 years. More than 300 additional provider-owned regulated health plans now operate in 43 States. Enrollment in provider-owned plans has grown significantly. Just as the vigorous growth among PSOs demonstrates that existing State licensure requirements have created a climate conducive to PSO development, it also demonstrates that current antitrust laws are compatible with PSO expansion.

The two-tiered, State and Federal regulatory scheme has proven effective in ensuring that Medicare beneficiaries, no matter where they live, receive promised benefits and services from viable entities. It's important to remember that many provider-owned entities are new, and safeguards in current law may be particularly important to long-term success.

In order to participate in Medicare today, HMOs must meet detailed Federal standards regarding operations, marketing, enrollment, disenrollment procedures, benefits, access to care, quality assurance programs, grievances and appeals, reporting and disclosure, solvency, and other enrollee protections.

H.M.O.s participating in Medicare must also be State licensed. To be licensed, HMOs and other integrated delivery systems must meet comprehensive consumer protection standards established at the State level, including standards addressing such areas as quality and accessibility of services.

In conclusion, in addition, the State licensure process provides a foundation for regulatory oversight and solvency. While AAHP strongly supports broader availability of health plan choices for

beneficiaries, we believe that beneficiaries should have the assurance that all options available to them today meet those same high standards.

Thank you very much.

[The prepared statement of Thomas R. Sobocinski follows:]

PREPARED STATEMENT OF THOMAS R. SOBOCINSKI ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

I. Introduction

Mr. Chairman and members of the Subcommittee, I am Thomas R. Sobocinski, President and CEO of Physicians Plus Insurance Corporation, in Madison, Wisconsin. Physicians Plus serves more than 100,000 members in south-central and southeastern Wisconsin. I appreciate the opportunity to testify today about provider sponsored organizations (PSOs).

Physicians Plus was licensed as an HMO in 1987 and, until May of last year, was entirely owned and governed by providers—by Physicians Plus Medical Group and Meriter Hospital. Today, providers continue to hold a two-thirds ownership and governance stake. We believe that Physicians Plus is an example of the right way for providers to take on health care risk. By forming Physicians Plus HMO, the Physicians Plus Medical Group and Meriter Hospital entered the insurance business and became subject to the same licensing and financial solvency requirements applicable to any other HMO insurer in Wisconsin.

I am testifying today on behalf of the American Association of Health Plans (AAHP). AAHP represents approximately 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other network-based health plans throughout the United States. Together AAHP member plans provide care for more than 140 million Americans. Nearly 20 percent of AAHP's member plans are provider-owned.

The health care market has changed in the two years since Congress first considered the issue of PSOs. In today's market, an increasing number of provider-owned entities—like Physicians Plus—are performing the same functions as HMOs and are complying with the same regulatory requirements.

Some providers have urged Congress to pass legislation granting PSOs participating in the Medicare risk contracting program[1] exceptions to current law. While AAHP supports the expansion of choices for Medicare beneficiaries as a way to improve the current program, this expansion must be accompanied by safeguards for beneficiaries and the Medicare program—by ensuring that all Medicare offerings meet consistent, national consumer protections. In addition, AAHP believes that entities performing the same functions—in this case, providing health care to Medicare beneficiaries—should be required to meet the same standards.

My comments today focus on the following specific areas: the rapid growth of provider sponsored organizations under current state licensure requirements for HMOs; current consumer protections and regulation of HMOs under the Medicare risk contracting program and their appropriateness for all contracting entities; and, the implications of current proposals for PSO participation in the Medicare program.

II. Growth of Provider-Sponsored Organizations

PSOs are growing rapidly in the marketplace under the existing state licensure and regulatory requirements for health plans. This growth makes it clear that, in contrast to the claims of PSO proponents, state and antitrust laws are not barriers to market entry. Physicians Plus stands as an example of a PSO that has succeeded in this environment for almost 10 years. Many other PSOs are new to the market. More than 300 provider-owned, regulated health plans now operate in 43 states. In addition to strong growth in the number of provider-owned HMOs and PPOs, enrollment growth among many of these plans has been increasing rapidly.

Modern Healthcare (June 17, 1996) reported that from 1994 to 1995, enrollment in the 10 largest provider-owned HMOs increased 16.7 percent, from 2.1 million to

[1] The risk contracting program is a program established under section 1876 of the Social Security Act that authorizes Medicare to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide Medicare benefits to beneficiaries choosing to enroll in them. HMOs and CMPs with a Medicare risk contract (often called "risk contractors") are paid a fixed amount per member per month for providing all covered services. A CMP is an HMO that has not chosen to pursue designation as a "federally qualified HMO" under title XIII of the Public Health Service Act, but meets similar standards for Medicare. For the remainder of this testimony, we use the term "HMO" to refer to both HMOs and CMPs.

2.4 million. For example, SelectCare, a provider-owned HMO located in Oregon, doubled its enrollment over the past three years to 151,000 while Paramount Health Care, a provider-owned HMO based in Ohio, increased its enrollment 187 percent over the past five years to 64,900. Examples like these underscore how well PSOs can prosper and compete under existing state laws.

In most states, this growth has been achieved by provider-sponsored organizations operating under a state HMO license. Thirteen states have enacted statutes or regulations specifically governing PSOs or provider networks, and the existing standards in many other state laws governing health plans are compatible with efforts by provider groups to form managed care plans. Recognizing the need for consistent regulation, the National Association of Insurance Commissioners (NAIC) is currently developing a model standard for entities that perform similar activities—regardless of the entity's governance, ownership or acronym.

Just as the vigorous growth among PSOs demonstrates that existing state licensure requirements have created a climate conducive to PSO development, it also demonstrates that current antitrust laws are compatible with PSO expansion. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have taken affirmative steps to foster the expansion of choices for health care consumers by promoting providers' and plans' understanding of the antitrust laws and their enforcement through timely issuance of advisory opinions. Further, the Department of Justice and the Federal Trade Commission last year issued revisions and clarifications to their antitrust policy guidelines on physician networks spelling out the types of situations in which providers can join forces and still comply with antitrust laws.

III. Current Regulation of the Medicare Risk Program

The current regulatory framework of the Medicare program was put into place to ensure that beneficiaries were provided adequate consumer protections. This framework has been developed based on extensive expertise, and has proven effective for beneficiaries, plans, and the Medicare program. It is important to remember that many provider-owned entities are new, and safeguards in current law may be particularly important to their long-term success. Indeed, we understand that in its upcoming report to Congress, the Physician Payment Review Commission will recommend that the same set of core standards be applied to all Medicare plans.

Where established standards have not been applied to organizations participating in public programs, problems have occurred. For example, in Florida, when Medicaid officials did not require all prepaid contractors to meet the same standards as those applied to commercial HMOs, the program was plagued by marketing fraud, and many of these entities lacked the financial reserves to provide high-quality care. In response to these problems, Florida now requires all prepaid plans participating in the Medicaidprogram to meet the standards for HMO licensure.

Role of Federal and State Regulation for HMOs under Medicare. The current two-tiered state-federal regulatory scheme has proven effective in ensuring that Medicare beneficiaries—no matter where they live—receive promised benefits and services fromviable entities.

In order to participate in Medicare today, HMOs must meet detailed federal standards on many aspects of their operations, including marketing, enrollment and disenrollment procedures, benefits, access to care, quality assurance programs, grievances and appeals, reporting and disclosure, solvency and other enrollee protections. These Medicare standards are designed to ensure that all organizations entering the Medicare program have the organizational structure and operational capacity to provide health care to Medicare beneficiaries.

HMOs participating in Medicare must also be state licensed. To be licensed, HMOs and other integrated delivery systems must meet comprehensive consumer protection standards established at the state level, including standards addressing areas such as quality and accessibility of services, member information, financial solvency, utilization review and grievance procedures. State licensure provides a level of local accountability to the federal regulatory standards.

States' expertise and infrastructure make state oversight of solvency an important foundation for federal oversight of plans contracting with the Medicare program. State solvency and capitalization standards are designed to ensure that health plans have the financial strength and stability to provide care to the patients they enroll. State capitalization standards are particularly important for new plans, because it is common for new organizations that provide as well as pay for health care services to sustain losses in their early years of operation. This is due in part to the fact that they must absorb the start-up costs of creating a delivery system and the infrastructure that supports it. Adequate solvency standards are particularly critical for plans serving Medicare beneficiaries because these beneficiaries use services more frequently and intensively than younger populations.

IV. Current Proposals Do Not Provide for Consistent Safeguards for Consumers

In contrast to the current Medicare regulatory framework, pending legislative proposals designed to permit PSOs to enter the program do not establish comparable standards among all organizations serving Medicare beneficiaries and do not provide comparable safeguards for Medicare enrollees. For example, HR 475, the Medicare Provider-Sponsored Organization Act of 1997, introduced by Representatives Greenwood (R-PA) and Stenholm (D-TX), would allow PSOs to participate in the Medicare program under a different set of rules than current Medicare HMOs. The bill proposes relaxed standards, even though the PSOs would be paid the same way and perform the same functions as Medicare HMOs. Available reports indicate that the PSO portion of the Administration's proposal takes a similar approach. At this time, we would like to take the opportunity to comment on HR 475.

While AAHP strongly supports broader availability of health plan choices for beneficiaries, we believe that beneficiaries should have the assurance that all options available to them meet the same high standards. The existing framework of regulation of HMO Medicare contractors has proven to be a solid foundation for expansion of the choices available to Medicare beneficiaries. Unfortunately, we believe that many of the modifications and additions to current law proposed in HR 475 would weaken existing consumer protections. AAHP looks forward to working with the sponsors of the legislation to address the following areas of concern:

Definition of a PSO. AAHP is concerned that the PSO definition fails to ensure a sufficient degree of integration among providers who comprise the organization. Using the bill's definition of "affiliation," the bill would permit arrangements under which independent providers share risk but are not under any common control. For example, a hospital and physician group could form an agreement, accept capitation, and share risk. But no third, separate entity in control of the two independent entities would need to be established, nor would the two need to be financially integrated. Such a loosely structured entity could easily disband—leaving Medicare beneficiaries without promised care and potentially damaging efforts to expand beneficiaries' choice by undermining their confidence in the stability of the plans available to serve them.

Preemption, Postponement, and Waiver of State Licensure. HR 475 would not require a PSO contracting with Medicare to be state licensed until January 1, 2002. At that time, state licensure would be required, but only in those states with licensure requirements equivalent to the federal standards and state solvency requirements identical to the federal standards. This provision raises the possibility of a permanent exemption from state licensing and consumer protection standards, if states failed to change their standards—in effect imposing federal standards on states that want to maintain regulatory oversight of health plans serving their residents. The bill makes it relatively easy for a PSO to have the state licensure requirement waived altogether—even if the state initially disapproves the PSO's licensure application. This provision would permit the Secretary to grant a waiver if the state were found to have applied requirements that impose "unreasonable" barriers to market entry. By not specifying in statute what constitutes "unreasonable" barriers to market entry, the bill provides a great deal of latitude for the federal government to waive state law.

The importance of the role of the states in licensure and in enforcing solvency and other standards cannot be overstated. States have historically been responsible for such oversight and have the experience and infrastructure in place to continue this role. AAHP strongly supports continuation of the requirement that all Medicare risk contractors be state licensed and supports the states' prominent role in developing and enforcing solvency and other licensure requirements.

Different Solvency and Insolvency Standards. HR 475 establishes different federal solvency requirements for PSOs that lack important elements of standards currently applied to Medicare risk contractors. AAHP strongly opposes weaker solvency standards for entities that perform the same functions and deliver the same services as other Medicare risk contractors. Provider groups have asserted that capital and solvency requirements should be lower for PSOs than for other risk contractors because if a PSO's funds are exhausted, the provider group can simply provide medical services without payment. However, beyond costs associated with the services delivered by their own providers, PSOs must pay for the cost of equipment, supplies, staff, and services—such as nurses' salaries, hospital overhead and medical equipment—that are essential to providing care. In addition, the complexity of the task of assuming responsibility for the financing and delivery of quality care argues strongly for ensuring that new entities have sufficient financial resources to succeed.

A critical protection omitted from PSO standards under HR 475 is the requirement that a plan must include in provider contracts a hold harmless provision. HMO contracts must have such a provision which requires providers to look only

to the HMO for obligations that are the HMO's responsibility and prohibits them from billing beneficiaries for these costs.

Deemed Status for Quality Assurance. The legislation contains detailed quality standards that—while largely consistent with current HMO quality monitoring and improvement requirements—put into statute what previously have been regulatory initiatives. The danger in this degree of specificity in statute is that it will freeze quality accountability to present day standards. Quality improvement systems and performance measurements are rapidly evolving, and the current statutory framework provides necessary federal oversight authority while permitting Medicare contractors to keep pace with this evolution. Consequently, we do not believe that the changes proposed in the bill are beneficial. In addition, while it makes sense to "deem" a PSO that meets current law quality standards through private accreditation as having met the federal requirements, it does not make sense to exclude other risk contractors from being eligible for deemed status. The deemed status option should be available to *all* Medicare risk contractors.

AAHP supports the development of criteria in connection with waiving the 50/50 enrollment requirement for Medicare HMOs. While the criteria in the bill are too restrictive and would potentially interfere with progress on quality improvement, AAHP supports further efforts to develop such criteria.

Minimum Enrollment Exception. AAHP strongly opposes the provision in HR 475 which would provide an exception for PSOs from the current law minimum enrollment requirements for their first three contract years and which would reduce the minimum enrollment requirements thereafter. The current minimum enrollment requirement was designed primarily to promote financial stability of plans receiving capitation payments under the Medicare program and to ensure that plans have a sufficient base over which to spread risk. Therefore, it makes sense to apply these requirements uniformly across all risk contractors. While we believe that the smaller population ban in rural areas justifies the rural exception in current law, all other organizations should meet the same minimum enrollment standard. AAHP supports uniform enrollment requirements for Medicare risk plans with a uniformly applied exception for rural areas and waivers during a plan's initial three years only if the plan demonstrates progress toward required levels.

V. Conclusion

Many PSOs are licensed entities performing the same functions as HMOs and other similar types of health plans. In examining legislation that modifies the existing, largely successful regulatory structure for the Medicare risk contracting program, AAHP urges Congress to ensure consistent application of consumer protections, including solvency requirements, to all contracting entities, including PSOs. A consistent approach to regulation will ensure that Medicare beneficiaries will have access to an increasing number of high-quality, affordable health care options into the next century.

Mr. BILIRAKIS. Thank you so much, Mr. Sobocinski.

Dr. Corlin, please.

STATEMENT OF RICHARD F. CORLIN

Mr. CORLIN. Thank you.

Mr. Chairman and members of the subcommittee, my name is Richard Corlin. I'm a practicing gastroenterologist from Santa Monica, California, and also serve as Speaker of the AMA House of Delegates.

We are pleased to be here today, and we believe that the case for PSOs is a compelling one, and yet regulatory obstacles stand in the way. Last year, we were successful in overcoming one of these obstacles. Despite massive opposition from the insurance companies, the FTC and DOJ opted for expanded consumer choice and increased competition. Last August they issued new antitrust guidelines for physician networks.

We are here today to seek your help in securing the remaining tools needed to promote the development of provider-sponsored organizations and provider service networks. Physicians are eager to develop PSOs and PSNs. We continue to be troubled by the threat

to patients when third parties intrude into medical decisionmaking. Physicians know that by using recently developed techniques we can reduce costs and lead medicine into a new era of improved quality for our patients at the same time.

The importance of physician leadership in health plans in well documented. Recent studies have touted the high performance of health care delivery systems which directly integrate physicians into medical and management decisionmaking. Yet fear of new entries into the market has caused the insurance industry to vehemently oppose any PSO legislation, just as they opposed the development of the Blue Cross-Blue Shield organizations in the 1930's and 1940's, and just as they opposed the 1973 HMO Act.

The AMA is pleased that Congress has acknowledged the importance of PSOs and PSNs by including provisions facilitating their development in the Balanced Budget Act of 1995. In addition, we note the introduction of H.R. 475 by Representatives Greenwood and Stenholm. We look forward to working with these sponsors to ensure that the full potential of physician and other health care provider-led networks is achieved.

The AMA believes that PSO legislation should have certain characteristics. First, just as did the HMO Act in 1973, this legislation should allow as much flexibility as is possible to stimulate innovation in the delivery of patient care. It should not favor any health care provider group over another in the ownership and management structure of a PSO. Balance must prevail so that medical ethics and patient welfare dominate over all other concerns.

Second, PSO legislation should contain tough consumer protection standards. Some of our opposition is claiming that we are asking for exemptions from provisions relating to quality assurance, marketing and enrollment protections, data collection, access to care, grievances, and conflicts of interest. Nothing could be further from the truth. Indeed, we have been the ones championing tougher regulations in these areas.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain antifraud and abuse laws, and self-referral laws, which were designed for non-risk-sharing arrangements and are inappropriate here.

Fourth, Medicare is a Federal program. PSOs should be subject to federally developed standards which recognize their unique differences. Many State regulators fail to account for the distinction between provider networks that deliver services directly and insurers that simply purchase health care services and then resell them. By developing a Federal framework, Congress will continue its precedent of encouraging new ventures that stimulate competition and provide efficiencies.

The 1973 HMO Act created a Federal regulatory scheme for HMOs, preempting State laws that interfered with their formation and operation. Over the objections of the insurance companies, HMOs argued successfully that they represented a different product and should be evaluated by different standards.

Finally, any legislative proposal considered by the House should also include the creation of PSNs. PSNs could contract with PSOs or other eligible organizations to deliver needed health care services. Provider networks offer a lot of evolution in the health care

delivery. The encouragement of PSOs, subject to Federal regulation, will benefit both the Medicare program and Medicare beneficiaries.

We thank you, Mr. Chairman, for the opportunity to share our thoughts. I would like to add two personal sentences at this point.

I find it ironic that the Blue Cross and Blue Shield organizations, and HMOs, both of which had to come to this body in times past for exemptions from existing legislation, in order to allow them entry into the market and to become competitors, would not object to somebody else doing the same thing. It represents perhaps the clearest example of getting into the lifeboat and then pulling up the ladder.

Finally, I would call your attention to the Congressional Research Service report, November 12, 1996, on Medicare restructuring and provider-sponsored organizations. The second paragraph, on page 6, I believe is the most succinct reason why these organizations should be allowed to prosper with Federal legislation.

Thank you.

[The prepared statement of Richard F. Corlin follows:]

PREPARED STATEMENT OF RICHARD F. CORLIN, AMERICAN MEDICAL ASSOCIATION

My name is Richard F. Corlin, MD. I am a gastroenterologist in private practice in Santa Monica, California. I also serve as Speaker of the American Medical Association (AMA) House of Delegates. On behalf of the AMA, I appreciate the opportunity to testify before this Subcommittee concerning the need for promoting greater patient choice of health plans in the marketplace.

Toward this goal, we commend you, Mr. Chairman, for holding this hearing on the need for provider sponsored organizations (PSOs). We look forward to working with this Subcommittee to create the framework necessary to stimulate the formation of PSOs dedicated to the delivery of high quality, affordable patient care.

Fulfilling the Promise of Antitrust Relief for Physician Networks

The market for health care finance and delivery is undergoing substantial change. It would be optimal if this transformation resulted in a greater choice of health plans for patients, including those formed by physicians, hospitals, or other health care providers to compete with insurance companies. However, regulatory obstacles block the way.

Last year, we came to Congress seeking relief from one of those obstacles—antitrust enforcement policies that chilled the development of physician-owned health care delivery networks and health plans. In response, House Judiciary Committee Chairman Henry Hyde introduced H.R. 2925, legislation that would allow physician networks the same antitrust treatment as joint ventures in other industries. The bill gained a formidable list of cosponsors—over 150 in all. Ultimately, the Federal Trade Commission and the Department of Justice agreed that changes were needed, and despite massive opposition from the insurance companies, issued new enforcement guidelines similar in application to Chairman Hyde's legislation. According to those agencies, the goal of the guidelines is to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."

We are here today to seek your help in securing the remaining tools needed to promote the development of PSOs and Provider Service Networks (PSNs). In so doing, Congress can improve health care quality by putting physicians and other qualified health care providers back in charge of medical decision making.

The Case for PSOs

Many physician networks have been successful in reducing health care costs while maintaining or enhancing quality. For example, a recent study in the New England Journal of Medicine, by James C. Robinson and Lawrence P. Casalino, reported on the cost performance of six physician-owned medical groups in California that accepted global capitation arrangements (which means that the physicians accepted the risk that patients would need hospital services as well as physician services). It found that hospital use by these groups in 1994 ranged from 120 to 149 days per

1,000 non-Medicare members, and from 643 to 936 days per 1,000 Medicare members. In contrast, the mean number of 1993 hospital days per 1,000 non-Medicare members for commercial health maintenance organizations in California was 232 days, and for Medicare members was 1,337. This is especially significant because hospital use accounts for by far the highest percentage of health care expenditures, and the primary source of savings achieved by managed care health plans has been reductions in hospital usage.

Underlying these developments, and making them possible, are changes in the way that physicians are approaching medical care. First, allopathic medicine is undergoing a period of comprehensive reassessment to determine what health care services are in fact beneficial to patients. Those found not to be effective are being discarded. Second, physicians are evaluating the best ways to coordinate the services of multiple providers used to treat an illness or injury. The object is to eliminate inefficient uses of resources and to improve the quality of the outcome of the treatment process.

This process of assessment and coordination is handled by groups of physicians who evaluate data about their performance, including cost and outcome, and then investigate the care giving sequence. They determine whether all services provided in the sequence were effective, and whether the services were provided in the most efficient way possible. Some have called this process "total quality improvement." This process is best handled by the physicians involved in providing the care. It is not possible for insurers or other intermediaries to engage in this process effectively, since they are not involved in the direct provision of medical care. They are too remote from actual health care delivery.

Insurance companies managed by non-physicians can, and have, reduced health care costs by placing restrictions on hospital stays by their beneficiaries. They enforce these limits with "preauthorization procedures," which require physicians to obtain approval for all hospitalizations from the insurance company. Insurers have done this by using non-physician personnel to enforce the limits during preauthorization procedures. These personnel usually communicate with physicians by telephone, fax or computer, and are often hundreds or thousands of miles away from where the care is being provided.

These limits do little to improve the quality of care provided and, more importantly, there is a limit on the extent to which these restrictions can reduce costs without compromising quality. Once hospital stays are reduced to the levels contained in the limits, there is little more that the insurer can do.

In order to achieve additional savings while actually improving quality, it is necessary for physicians to gather data about the exact services provided to treat an illness or injury, how the services were provided, the cost, and the outcome. By engaging in a critical review of the details of the process, they can determine the best services to treat an illness or injury, thereby improving quality, and the most efficient provision of these services, thereby reducing costs. This is a much different process than placing arbitrary limits on hospital stays or denying coverage for various kinds of treatment.

That is why PSOs and PSNs are so important to the future of health care in our country. They are health care delivery systems owned by physicians and other health care providers that are designed to maximize cost savings and quality by engaging in this process. Their development is essential to reach the next level of cost savings while enhancing quality of care.

In general, PSOs are defined as health care delivery systems owned and operated by physicians and/or other health care providers with the ability to provide a substantial part of the Medicare benefit package pursuant to risk sharing arrangements. A PSN is a provider network that does not have the capacity to deliver a substantial portion of Medicare benefits, but which can contract with PSOs or other eligible organizations to deliver care pursuant to risk sharing arrangements

Physicians and other providers are eager to develop PSOs and PSNs. We are concerned about third party intrusion into the patient-physician relationship and, ultimately, medical decision making. We are troubled about judgments being made about the care of individual patients pursuant to restrictions imposed from remote sites by non-physicians. Physicians and other health care providers believe that we can not only reduce costs but lead medicine into a new era of improved quality if we can take back the reins.

The AMA is pleased that Congress acknowledged the importance of PSOs and PSNs by including provisions meant to facilitate their development in the Balanced Budget Act of 1995, which was subsequently vetoed by President Clinton.

In addition, we note the introduction of the "Medicare Provider-Sponsored Organization Act of 1997" (H.R. 475) by Representatives Greenwood and Stenholm. This legislation would allow PSOs to provide benefits to Medicare beneficiaries without

unnecessary insurance middleman. The legislation would establish standards that qualified PSOs must meet in order to serve Medicare patients such as solvency requirements, licensing requirements, and enhanced quality standards and consumer protections. We commend the sponsors of this legislation for moving the PSO debate forward this year in the House. We look forward to working with Representatives Greenwood and Stenholm to ensure that the full potential of physician and other health care provider-led networks is realized.

The AMA's Vision of PSOs

The AMA's plan to transform Medicare is based on expanding the choice of health plans available to Medicare beneficiaries, including PSOs and other eligible organizations that partner with PSNs. Congressional action is essential to fostering the formation of these entities. The AMA believes that PSO legislation should have certain characteristics.

First, the legislation should allow as much flexibility as possible to stimulate innovation in the delivery of patient care. Legislation should not favor any one PSO model type or any health care provider group over another in the ownership and management structure of a PSO. The market should determine what PSO models and ownership structures are the most successful.

With regard to flexibility, the AMA is concerned that H.R. 475 would favor the hospital-owned or physician/hospital organization (PHO) model to the exclusion of others. The AMA believes that physician networks and large group practices should also be able to lead the formation of PSOs. This is important to the public because it is ultimately physicians who must engage in the process of evaluating medical care to improve its quality and reduce its cost. Again, we believe these decisions should be left to the market to determine.

Indeed, the importance of physician leadership is borne out by research. A recent study led by Stephen M. Shortell, a Professor of Health Services Management at Northwestern University, found that health care delivery systems which had significant "physician-system integration" performed better than those that did not. The author defined physician system integration as the degree to which physicians use the system, including being involved in the planning, management, and governance of the system. The study also found that the higher the degree of physician-system integration, the greater the delivery system's inpatient productivity. The study noted that "(i)t is simply not possible to achieve any measurable level of clinical integration for patients without a close relationship of physicians with an organized delivery system."

Second, PSO legislation should contain tough consumer protection standards. Such standards should include requirements that PSOs use continuous quality improvement methods, evaluate continuity of care, monitor the over- or under-provision of care, provide information to help beneficiaries choose plans and require coordination of utilization review with a PSO's quality program.

The AMA has long been committed to protection of the patient. The AMA has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance. As you may be aware, the AMA last year approved the development of an accreditation program for physicians. Subsequently named the American Medical Accreditation Program (AMAP), the program is designed to establish national standards of physician performance.

Recently, AMAP took its first step toward implementation and announced that it is ready to approve self-assessment programs for inclusion in the AMAP program. As a result, AMAP has invited those entities with self-assessment programs to submit them for review. In addition, the AMA is unveiling this week our perspective on a set of health plan characteristics that we believe to be essential to the operation of a quality managed health care plan. The document, entitled "Essential Characteristics of a Quality Health Plan," describes what makes for "good" managed care, including patient rights, continuous quality improvement, accreditation and respect for the patient-physician relationship. We look forward to working with the Congress on these quality improvement initiatives.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain anti-fraud and abuse laws and self-referral laws. These laws were designed to regulate the conduct of physicians in independent practice under traditional fee-for-service medicine, and they were intended to prevent the provision of unnecessary care. The laws make sense for the regulation of fee-for-service arrangements where the physician may have an incentive to provide unnecessary care. However, they have no purpose in the regulation of networks that are designed to reduce the provision of unnecessary care, especially when the networks are involved in risk sharing arrangements in which physicians have an incentive to reduce unnecessary care.

Another regulatory obstacle is pension regulations pursuant to Section 414(m) of the IRS Code. They may require that physicians who form certain kinds of networks aggregate their pensions and comply with the nondiscrimination provisions. Those provisions could have a material adverse effect on the retirement plans set up by individual physicians. This could discourage physicians from developing networks.

Fourth, solvency standards should reflect the unique characteristics of PSOs. In spite of the potential benefits of having physicians direct health plans, in 1994 only 6.4% of health maintenance organizations (HMOs) were owned by physicians, physician medical groups, physician hospital organizations (PHOs), and state medical societies combined. This is due in part to the chilling effect of state insurance and HMO regulations that fail to account for the distinctions between provider networks that deliver services directly and traditional HMOs and insurers that purchase health care services and resell them.

There are dramatic differences between provider organizations that assume risk and insurance companies. Provider organizations exist for the primary purpose of delivering health care services to patients. To the extent that they enter into risk sharing arrangements, they do so for the primary purpose of delivering health care. The assets of providers that enter risk sharing arrangements are concentrated in health care delivery. A way to better understand this concept is to consider the analogy of repair warranties issued by car manufacturers. These warranties involve the assumption of risk, and are a significant financial commitment. However, car manufacturers offer them for the primary purpose of selling cars, and the assets of car companies are concentrated in car manufacturing.

In contrast, the primary purpose of insurance companies is to profit by underwriting risk. Insurance companies do not deliver health care services. They buy them to the extent necessary to satisfy claims. Insurers seek to profit by investing the spread between premium income and claims in financial securities such as stocks, bonds, mortgages, and other investments. Their assets are concentrated in such liquid securities, not in health care delivery. However, the regulations of most states, including solvency standards, statutory accounting principles, and financial reporting requirements, are designed for insurance companies, not provider networks that assume risk. They typically require that insurers maintain a substantial amount of liquid assets and maintain a financial management system that identifies those liquid assets for insurance regulators. This suits the business of insurance well because insurers typically maintain a substantial amount of liquid assets in the ordinary course of their business, and if they do not, then they are likely to be in danger of becoming insolvent.

State regulations do not fit the operations of health care providers. Health care providers normally do not maintain substantial liquid assets. However, that does not mean that they are in danger of becoming insolvent. Their assets are concentrated in health care delivery, and they have the capacity to deliver services for which they assume risk. That does not mean that provider networks can sustain substantial and unexpected catastrophic losses, but they can sustain themselves longer without liquid reserves because of their health care delivery assets.

Because of this, and because of the particular demands of the Medicare program for uniformity in administration and operation across the United States, PSOs should be subject to federally-developed solvency standards which recognize their unique differences. Solvency standards should recognize the value of assets used in health care delivery as well as ways of responsibly handling risk such as reinsurance, capitation, and fee withholds. PSOs are critical to the success of a reformed Medicare system based on free market competition; it is essential that they not be forced into inappropriate state regulatory structures that would compel them to become HMOs, thereby eliminating them as a separate option under Medicare.

By regulating PSOs at the federal level, Congress will follow its precedent of encouraging new ventures that stimulate competition and provide efficiencies. A notable example is the Federal HMO Act of 1973 that was intended to, and did, facilitate the development of HMOs as a means of increasing access and lowering costs. At the time, HMOs faced legal barriers including state solvency requirements viewed as not recognizing their particular characteristics. To remedy the barriers, the Act created a federal regulatory scheme for HMOs that preempted state laws that interfered with their formation and operation. These provisions included grants and loan guarantees for the formation of new HMOs, solvency requirements different from those of other health plans, and a mandate that employers offer HMOs available in their geographic locations as a health benefit option to their employees. In comparison, the provisions to facilitate PSOs are modest in scope.

Finally, any legislative proposal considered by the House should also include the creation of PSNs. PSNs, owned and operated by physicians and other health care providers, could contract with PSOs to deliver health care services.

Physicians usually begin the process of managing care with a PSN, because the development of skills and capacity necessary to operate a PSO takes time and experience. These networks typically begin with simple arrangements that are easy to manage, such as discounted fee-for-service networks, and then enter into risk sharing arrangements that require greater managerial sophistication. If the network is successful and is able to manage greater and greater amounts of risk, meaning that larger amounts of services and patients are included in these arrangements, the network could evolve into a provider-owned health plan such as a PSO. Therefore, PSN development is important to the creation of PSOs.

Setting the Record Straight

Fear of competition has caused the insurance industry to vehemently oppose any PSO legislation. Since most insurance companies are corporate profit-making entities, first and foremost, it is to their advantage to keep physicians, hospitals and others out of the market. Insurers argue that different solvency standards for provider networks will put patients at financial risk.

The reality is that insurance companies are making the same arguments against the House provisions for the regulation of provider networks that they used in the 1970s to oppose HMO laws. HMOs argued successfully that they represented a different product and should be evaluated by different standards. Established insurers will maintain an unfair competitive advantage if provider networks are required to meet the same standards as insurance companies. Patients will ultimately bear the unnecessary cost of excessive capital requirements. Physician and hospital networks are different than insurance companies and commercial HMOs that operate as third party payers. PSOs must and should be required to meet high standards that guarantee consumer protection and quality assurance. But they should not be treated as something they are not: insurance companies.

The insurers also argue that PSOs would lack consumer protections without state licensing. The reality is that pending legislation before the House and Senate would apply current Medicare consumer protections to PSOs, such as grievance and appeals processes and enrollment and marketing standards. Enhanced quality standards are also required by the legislation, including continuous quality improvement methods and evaluation of continuity of care.

Finally, the insurers argue that state insurance regulation will better protect consumers. The truth is that insurance companies have a checkered history on patient protection. Several plans have either suffered unfavorable court rulings or have been forced to refund millions of dollars bilked from beneficiaries. Tax-favored plans in certain states have overcharged patients by failing to pass on discounted rates and have collected excessive patient co-payments.

Conclusion

The case for PSOs and PSNs is compelling. Yet, provider networks will be unable to present a meaningful alternative to insurance company plans, and, thereby, improve the competitive process, if they are not permitted to operate effectively. The encouragement of these networks subject to federal regulation will benefit both the Medicare Program and Medicare beneficiaries. Mr. Chairman, the AMA looks forward to working with you and the Subcommittee to ensure passage by the Congress of meaningful PSO and PSN legislation. We thank you for the opportunity to share our thoughts and concerns.

Mr. BILIRAKIS. Thank you, Doctor.

You, in a sense, took my question away from me. On the other hand, it's all right. You asked it maybe in a much better way than I could.

Mr. Gradison, Ms. Lehnhard, would you respond to Dr. Corlin's point regarding the fact that back at that time, 20-some years ago, your organization had to go to the Federal Government for protection against what, I guess, were barriers?

Mr. GRADISON. That's not a very good answer, Mr. Chairman. I wasn't around 20-odd years ago, or I probably would have been where you are.

Mr. BILIRAKIS. Well, do you know the answer to that? How would you respond to that charge?

Mr. GRADISON. I do not know the answer to that. The fact of the matter is that the PSNs are being created. The largest HMO, in

my old district in Cincinnati, started as a provider-sponsored organization created by the Academy of Medicine. So the notion that there is some limitation out there that keeps these from being formed is simply not true.

As a matter of fact, I think, if we were to inventory the membership of the three organizations that are sitting here, we could come up with some pretty impressive numbers—in fact, I think it's in the testimony—about how many PSNs are already licensed as HMOs and are members of our——

Mr. BILIRAKIS. Mr. Gradison, with all due respect, could you take us back, history-wise, to the early days of HMOs? And is it true—I think Mr. Stenholm made the comment that the insurance industry had to go to Congress because they ran into barriers, and that sort of thing. Can you take us back to those days, to what the history was?

Ms. LEHNHARD. Yes, sir, I can respond to both of those.

With respect to the HMO law, that was a very clear case where States outlawed the corporate practice of medicine. They didn't allow HMOs, and the Federal Government had to come in override that. That's not the whole story, but that's a key part of it.

With respect to Blue Cross and Blue Shield plans, we've never come to the Congress because of market barriers in the States.

Mr. BILIRAKIS. You wouldn't be in business today, though, were it not for that 1973 law; isn't that correct?

Ms. LEHNHARD. No.

Mr. BILIRAKIS. In terms of your HMO?

Ms. LEHNHARD. No. We were in the managed care business, but we were in business in 1946 without the assistance of the Federal Government.

I have my own response to his analogy of the lifeboat. I think what we would say is, what the PSOs are asking for now is not to lower the bar but to take the lines off the road. It's a question of what rules are you going to play by. There are lots of PSOs in the market, and what we hear them asking for is to waive the most basic consumer protection laws.

Mr. BILIRAKIS. You concern is?

Ms. LEHNHARD. They are not impeding their entry into the market. Fourteen percent of HMOs are PSOs.

Mr. BILIRAKIS. Your concern is the consumer?

Ms. LEHNHARD. Absolutely.

Mr. SOBOCINSKI. May I add to that, very quickly?

Mr. BILIRAKIS. Please.

Mr. SOBOCINSKI. Very simply, my understanding of the Act was three forms of assistance: Federal grants, loans, employer mandates to offer the HMOs, and superseding of restrictive State laws.

In our particular case, we did not come forward, but also, in our State insurance commissioner's office, there were the requirements for certain surplus requirements right from the get-go, and we complied with that. We did not see the Federal Act as superseding the State laws that existed for surplus requirements. And we then came together, as provider-owners, with capital equity.

So I take issue with the remarks. I understand where we're coming from here. I'm not here to debate the model. I'm here to debate

whether the protections for the consumers would be adequate in what we're talking about today.

Mr. BILIRAKIS. The Wisconsin plan is something that we've heard an awful lot about over the years. I commend you and all the others responsible there, because I hear nothing but good things.

Without going into any details as to the makeup of it, and I really don't remember too much of that anyhow, I will ask you, do you honestly feel that, no matter which State you wanted to put that plan into effect today, that you would have just as easy a time to get approval, by every State insurance commissioner, as you did in Wisconsin?

Mr. SOBOCINSKI. I can talk real examples in a State where we have—Illinois and Wisconsin. Got it ready with agent licensing, with medical determinations, reciprocal agreements, where we found there was a good thinking, an adaptation to allow for this kind of managed care service to the public to take place.

I would suggest also with a minority partner, which is covering with a minority stake for us. We are seeing the opportunities that if we can get over this common hurdle that is always a challenge to HMOs, that we can't cross department or State lines to provide other coverages outside of our immediate region.

So I think that yes, in answer to your question, I'm optimistic in looking forward, that the State regulatories, through various insurance commissioners, do not pose a major obstacle for us.

Mr. BILIRAKIS. Do you know of any instances where they possibly may have posed unreasonable obstacles for other plans, plans other than yours?

Mr. SOBOCINSKI. I couldn't address that, sir.

Mr. BILIRAKIS. Well, my time is up.

Mr. Brown.

Mr. BROWN. Ms. Lehnhard, what consumer protections, specifically, were you talking about in response to that question?

Ms. LEHNHARD. The one I mentioned in my short statement, that I think is the most important, that I think is really being overlooked, and it's been said by the people who have testified in support of these Federal proposals, that they are the same as the NAIC. I think there's a tremendous difference.

The NAIC has very clear liquidity tests, how liquid you have to keep your assets. Take a small, rural PSO, 30 percent of their services may be provided out of area, in the urban hospital, for tertiary care. The NAIC would say, "We want you to have enough liquid assets so that you have cash to pay for people to go into the urban area."

This bill would tie the hands of the States and the Secretary to set liquidity standards. You could not set any liquidity standards. The PSOs could use their actual hospital and their parking lot to meet these liquidity standards, in case—the whole idea that, if you underestimate your claims and you need cash for people to go into the city, they would say, "Well, we can't sell our hospital." The Secretary would have absolutely no leeway to set the kinds of standards that the States have set.

Mr. BROWN. Mr. McMeekin, what sort of protections do you have in place to prevent beneficiaries from being harmed in the event of your organization's insolvency?

Mr. MCMEEKIN. Well, remember, we're a demonstration that's only about a month old. But, first of all, I think, as providers, the whole issue of consumer protection is as direct as you can get. There is no middle organization, like an insurer or a managed care organization, that you have to apply through or send your grievance through. When you're talking to your physician, and he or she does something that you're not happy about, you tend to address it right then and there, and that's the way we think it should be.

I think the issue of solvency is something that the American Hospital Association and providers across the country feel equally strong about. We do not want to have new models of choice actually cause more of a problem than we think the new choice offers, in terms of encouraging more managed care.

But I do think we feel comfortable that the Act, as currently structured, does adopt the Federal HMO certification language, and, in fact, the NAIC model bill recognizes the assets of health systems. So I don't believe that we think we're that far apart. In no case would we support anything other than good, solid solvency requirements and beneficiary grievance procedures that we think are just absolutely necessary in this kind of an offering.

Mr. BROWN. You indicated, Mr. McMeekin, that you advocated that the 50/50 rule should be waived, so half of your enrollees would not have to be commercial enrollees. Having only Medicare beneficiaries, it seems to me, raises issues of spreading risks. Is a PSO able to spread that risk, take that chance of having a huge number of Medicare beneficiaries, with a generally more expensive patient load?

Mr. MCMEEKIN. We believe so. The reason we would advocate removing the 50/50 rule is because PSOs, as the American Hospital Association understands them, have no interest in becoming HMOs. They have no interest in getting into the commercial market. So to have a 50/50 rule, in that context, just sort of puts you out of business.

We think this is a Federal program. We think this is a Medicare program, at least the bill is talking about Medicare only. In terms of the question of the actuarial side of Medicare, in our case, and to the satisfaction of the Health Care Financing Administration, we believe that, with stop loss insurance and other prudent measures, you can very well manage the health and provide the care to Medicare beneficiaries without getting into difficulty.

The advantage a PSO has is that, right off the bat, it eliminates up to 15 or 20 percent of expense that is otherwise in the cost of health care, as it's currently and traditionally structured in this country.

Mr. BROWN. Administrative costs.

Mr. MCMEEKIN. Administrative costs. Just the added redundancy in utilization review, in credentialing. The network development of a typical insurer is a very costly process. If you already have a network in place, you don't have that cost. So that cost or those dollars then get funneled into providing care.

In our case, there is a commitment to try to build a healthier community. So, in a sense, if we're successful, as we believe we will be, not only actuarially do we feel comfortable, but hopefully we will reverse some of what today is that risk in the elderly popu-

lation, by letting them get back in and take charge of their care, which I'm afraid has not been the case up until now. We have put the patient out of the equation.

Mr. BROWN. If I understand this right, under the Stenholm-Greenwood bill, we would eliminate the 50/50 requirement. And since doctors typically have relationships in a community with specific patients who have been to see them there is the risk of the adverse selection which could put PSOs at greater risks than HMOs.

Doctors have closer relationships with people who are sick than people who are well, unlike HMOs, who are so good at typically cream-skimming. So there exists adverse selection. I don't mean to raise a whole issue here. Sorry about that.

Yes, I just did. Okay. I did, I did. All right, I did mean to.

Doesn't the possibility exist that under these circumstances a PSO runs a greater risk of insolvency and putting government in a position, again, of bailing out an insolvent plan, where taxpayers have to pay twice? Because the Medicare beneficiary is going to get fee-for-service, if that happens. What's wrong with that way of thinking?

Mr. MCMEEKIN. I would differ with you, Congressman, in just two quick ways. One, we are not fighting the solvency question. We think it ought to be appropriate test to prove your solvency. It's only a question of how that's calculated and what assets are included.

The part of the adverse selection, I think there is probably a risk there, but that's a risk that I think we, as providers, are quite willing to take on, because it's not a new risk. We're taking care of people today. The opportunity of a PSO is to manage care, as compared to the insurer who is in the business of managing cost.

If we can manage that care, I'd be happy to have our members see as many doctors as they can, if, in fact, they are being managed to stay well and build their health status, as compared to being caught under gag rules and put into a 24-hour kind of medicine where, in fact, they are not getting the kind of care they should until it's so critical and so expensive that there's no argument.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. The gentlelady from California.

Ms. ESHOO. Thank you, Mr. Chairman.

Sometimes the more I listen, I think, the more confused I get. The HMOs have what they have, are pretty pleased with what they have, and feel that it's working well. We have constituents that agree, at least in many instances.

Now there's another group that wants to come along and do things under a similar configuration, in terms of taking care of people, but it is a little different under the law than how HMOs operate. And the HMOs have gotten what they want. You want what you want, and what you want gets in their way. So we're referees here.

I'm worried about this solvency issue. I think that there is, certainly, a good case to be made where physicians and hospitals come together. Not too much has been touched on relative to antitrust, and I know it's an antitrust issue. So, without having read the legislation, and we didn't get much time to ask our colleagues, I'm

sure that that's addressed or touched on somewhere, because antitrust has stood in the way of that.

Now, our colleague, Mr. Stenholm—and I did ask him this question, because he touched on insurance—if you have to leave out your facilities, and you have to go just buy insurance, in case something happens—I'm using very plain language, but that's what people really count on—I don't know how anyone can take their facilities into configuration. You're not going to sell them off. Who the heck is going to buy them? If you're not doing well, you're failing, you're insolvent, who cares what you have in terms of a building, or an MRI, or whatever?

Maybe someone will come and scoop up for 25 cents on a dollar, but that doesn't do too much in terms of solvency. So are the PSOs prepared to buy insurance on the market to insure themselves against insolvency, leaving out what I just described? And I guess, as I do that, I'm opening a can of worms, because I think the HMOs have a formula where facilities and equipment, and whatever, are valuated against solvency, as well.

Ms. LEHNHARD. May I make one correction?

Ms. ESHOO. Sure.

Ms. LEHNHARD. It was mentioned that the NAIC allows facilities to be counted, and they don't. Under the NAIC HMO Investment Act, HMOs are not allowed to count facilities in meeting the liquidity test.

Ms. ESHOO. So that's not part of solvency?

Ms. LEHNHARD. The commissioners have said no, because it's not cash on hand.

Ms. ESHOO. In all the States?

Ms. LEHNHARD. The NAIC Model Act and—I couldn't speak for all the States. I know it's the large majority of States.

Ms. ESHOO. Okay. That's instructive.

Mr. MCMEEKIN. Congresswoman, we know that only 29 States have adopted that NAIC model bill. But if I understand it, it requires $1.5 million and 3 months' reserves. That is no different than our understanding of the bill in front of you today, 475. It also provides some discretion to the Secretary to increase or change or modify that requirement.

So in a sense, it meets what I think is a reasonable test but allows even more. And, again, the quality assurance is, likewise, a higher bar, a much higher requirement, we think a more appropriate and more modern requirement, in terms of protecting the quality of the consumer of a PSO.

Ms. LEHNHARD. The NAIC net worth requirements, there are four of them, and the proposed Federal bills have three of them. They have left out the most stringent one.

Ms. ESHOO. Which is what, in your view?

Ms. LEHNHARD. It's 2 percent of the first $150 million of premium, and that's not in the Federal bills.

Ms. ESHOO. Let me ask you this: If the Federal legislation were changed to make the standards the same as to what HMOs have to—the muster you have to pass now, that the PSOs had to do the same, they come under Federal regulation, would you fight that?

Ms. LEHNHARD. There are really two bodies of regulation that we meet: one is the financial standards, like in the NAIC.

Ms. ESHOO. I understand. Yes, you want that in.

Ms. LEHNHARD. The other one is a very broad range of consumer protection laws. For example, Maryland requires brokers who sell Medicare risk products to be relicensed every 2 years.

Two 85-year-old ladies living next door to each other, one of them is going to be sure that her broker is certified and regulated by the State. The lady next door is going to be regulated by the Federal standards, and her broker won't be regulated. You're going to get people questioning, you know, who is regulating my health care?

Ms. ESHOO. Well, let me just say to you that there are a lot of people who are confused with what's out there right now. We're kidding ourselves if we think that there is just national clarity on what's going on in every community relative to health care. If it were, then I wouldn't have any casework in my office or be answering questions.

You can tell that I'm open on this. I think that there's, again, a case to be made for doctors and hospitals coming together. I like different ideas and choices for people. I'm open to that. But if we could settle this, in terms of some kind of standard, why can't the Federal Government come up with some standards to help these people out?

The doctors don't like doing business with you. You already know that. You've already told them that they are a commodity. So now the hospitals and the doctors want to come together; they want to offer another service. So if we come up with some Federal standards, and we come up with something different—I don't like this business of the buildings and whatever being figured into solvency, because I think, if someone is starting to have problems, geez, 10 cents on a dollar for what you hold.

What did you want to say, Mr. Gradison? I know that you are skilled in all of this. What would make it acceptable to you?

Mr. GRADISON. Well, one alternative that was considered earlier by Congress was to directly address this concern, on the part of some of the PSOs, that the States would drag their feet. And that was to give the States the first opportunity to license these institutions, with the clear understanding that, if the State did not, within a certain period of time, act, then there would be a Federal fallback to review it. I think that that may be an avenue which you might wish to explore further.

Ms. ESHOO. Can I just have a minute, Mr. Chairman?

Mr. BILIRAKIS. By all means. In fact, I planned to go around maybe a second time.

Ms. ESHOO. Thank you.

Mr. BILIRAKIS. So you're on your second time around.

Ms. ESHOO. Okay. That's great. Now I forgot what I was going to say. See how normal we are? We're just like everyone else.

I am a bit uncomfortable about leaving this issue to rest with the commissioners, as much respect as I have for them, in the 50 States. I think that we're capable of coming up with something; I really do. And I think it's a situation where there is a legitimate role for the Congress to act on this, in order to help to give people choice. It's a matter of straightening out where you all don't like it or will be fighting it, you see, where you don't think it's fair.

Maybe what I'm saying to you is that what you've presented so far is not all that provocative to me. See? You don't like it for what reason? I know that there will be competition. You like the competition; you are competitors, but the fed is in, essentially; right? You take business away from the feds, in terms of fee-for-service, but we send the checks to you. So now what is it that is so unsettling?

Ms. LEHNHARD. I've asked our CEOs that very question. What they have said to me is that they are not worried about undercapitalized entities, whether it's PSOs or HMOs, in the marketplace.

Ms. ESHOO. "They" being you?

Ms. LEHNHARD. Blue Cross and Blue Shield. What they are worried about is the market disruption that occurs when these entities startup, enroll people, go bankrupt. It's not only unsettling to beneficiaries, but it's unsettling to the whole pricing structure in the market.

Ms. ESHOO. Well, bankruptcy hasn't happened. What we want to do is to make sure that we build in, if the legislation is going to fly, the appropriate yardsticks to measure solvency, so that we protect the very people that we offer Medicare to or that are beneficiaries. Right?

Mr. SOBOCINSKI. If I may follow this same area.

Ms. ESHOO. Right.

Mr. SOBOCINSKI. And I do want you to know.

Ms. ESHOO. I think we're talking past each other, or I'm not making myself clear.

Mr. SOBOCINSKI. No. I think I'd like to proceed on this.

Ms. ESHOO. Okay.

Mr. SOBOCINSKI. First of all, I do want you to know that there are physicians currently wanting to talk ownership with us and equity positions. So there are providers that want to compete.

Ms. ESHOO. Are you willing to talk to them, though?

Mr. SOBOCINSKI. Yes, absolutely. As a matter of fact, we have an agreement and it's on the table. But one of the things—and I am president and CEO for my company, but prior to this I was a founder, a hospital administrator, and switched roles as a trustee, so I'm trying to look at this from a number of different perspectives.

Very simply, I know we're talking about the individual Medicare recipient, but I've dealt with many Fortune 500 companies that wanted—they had liabilities in terms of group Medicare risk.

Ms. ESHOO. Could you just talk about the point that Ms. Lehnhard made, that you wanted to make?

Mr. SOBOCINSKI. Well, I wanted to come back to the importance, though, of why we haven't made any difference here. I would like to see some commonality, that if we're dealing with a corporation that has Medicare risk responsibilities, liabilities, whether it's a Chrysler Corporation that we've dealt with or when it comes down to the individual consumer, we have mechanisms in place—and I speak with pride, in terms of our particular State—it works well. And why put a blur, another kind of provision that would be another layer, some confusion to it?

As to your question about standards on solvency.

Ms. ESHOO. What's the confusion, though? What's the confusion? What's the layer, that there's another organization that does business, that is similar to yours, but the guidelines and the standards say, maybe, at the end of this, may be regulated in a Federal model rather than the State? Why is that disruptive? Why is that bad? You haven't convinced me yet, see. So why is it? Tell me.

Mr. SOBOCINSKI. I was not going to say that in terms of the models, because I said earlier I'm not against competitive models.

Ms. ESHOO. What are you against?

Mr. SOBOCINSKI. What I do have some concerns about is the adequacy of the solvency. You say it will be addressed. I have some healthy concerns about that. We do not have Medicare risk. One issue is the rates. The other healthy concerns we have, in terms of going as provider ownership, a partnership, willing to meet market demands, public sector, private sector, is, is this a hurdle or a barrier, or is it the skirt of what you're talking about today? I don't know, and I say it in that spirit, in response to you.

Mr. GRADISON. Ms. Eshoo.

Ms. ESHOO. Yes, Mr. Gradison.

Mr. GRADISON. In a sentence, I think the concern is this: If you're going to erect standards for offering these risk plans to Medicare beneficiaries, let it be uniform. And I'm not here, at this particular point, to argue where they ought to be. But to have some of them go to the States and others who are competing in the marketplace go to the feds, with two different standards, does raise questions from the point of view of those who want to compete and expect to compete in that market.

I mean, make your mind up. Go one way or the other. But to divide this with two different standards really is going to raise some serious problems in the long run.

Mr. BILIRAKIS. Would your entity, sir, settle for Federal standards?

Ms. ESHOO. I was just going to ask that.

Mr. GRADISON. I tried, Mr. Chairman. I think, at this point, I think, if you go with Federal standards for all Medicare risk contractors, that it will just be a flash of time before Medicaid asks for the same thing. And the—under the legislation passed last year, we're going to end up, rather quickly, with largely Federal regulation of health insurers.

I'm not prepared to give you advice on that, except to say that the action that you take here will definitely, in my view, determine what's going to happen down the road. If you're comfortable with the idea of greater Federal regulation of health insurance, generally, starting with Medicare and Medicaid, then you might as well go ahead and do this.

Mr. CORLIN. Mr. Chairman.

Mr. BILIRAKIS. Yes, Doctor.

Mr. CORLIN. May I have the opportunity to respond, as well?

Mr. BILIRAKIS. A vote has been called, so we're going to really have to break this thing. Will you please respond, and I think we'll probably finish up.

Ms. ESHOO. Thank you.

Mr. CORLIN. Yes, thank you. Ms. Eshoo, I think you hit a lot of very key points. The important thing, I don't think the responses

you've gotten, to this point, responded to what you said. The issue of a State standard versus a Federal standard is an absolute myth. There is no uniformity among the States.

The State of Wisconsin, for instance, has perhaps among the most liberal State insurance laws, with requirements for solvency even below what the NAIC recommendations are. Large numbers of organizations have self-insured and escaped State regulation completely, into the ERISA laws. So trying to say that the horrible nature of this law is that it would break the sacrosanct State control over insurance is a myth. It just is not the case.

What is the case is that a group of providers, who are interested in working in a capitated arrangement, assuming risk, thereby obviating the antitrust needs that you so correctly brought up, in the absence of shareholders who are simply sitting home clipping coupons with Medicare money, want to be able to provide an alternative to care and do it in an environment that they can responsibly enter the field, recognizing that, at the beginning, there has got to be a ramp up of the solvency requirements.

There are a lot of protections that are built in. We're not saying no solvency requirements. I think, if you want to get perhaps one of the most instructive bits of information you can, get Brent James to come in from Intermountain Health Care, in Salt Lake City, to take a look at the system they have built, absent an insurance company, and it probably is one of the finest in the country, lower costs and massively improved quality.

We believe this system can work; it needs some Federal help to do so. And we are perfectly willing to abide by and live under any appropriate Federal oversight, but we need some help from you to do it.

Mr. BILIRAKIS. We really, speaking, I know, for myself, and I'd like to think for all members of our committee, we are willing to work with you. We want to work with you. There's just no question about it. I think we all agree that PSNs, PSOs are on the way, just like HMOs or, God knows, managed care is not only here but certainly expanding. So we want to do it right.

Without objection, there may be additional questions that we might furnish to you, and we would appreciate a nontardy response to them, because, again, if you have an opportunity to input to us, the sooner you do that the better, obviously, for all of us.

Well, listen, thank you so much. Again, I appreciate your patience.

The hearing is adjourned.

[Whereupon, at 4:50 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

PREPARED STATEMENT OF JAMES L. SCOTT, PRESIDENT, PREMIER INSTITUTE, PREMIER, INC.

Mr. Chairman, I am pleased to write you today on behalf of Premier, Inc., the nation's largest healthcare alliance. Premier represents more than 240 owner hospitals and hospital systems that own or operate 700 healthcare institutions and have purchasing affiliations with another 1,100. Premier owners operate hospitals, HMOs and PPOs, skilled nursing facilities, rehabilitation facilities, home health agencies, and physician practices. Through participation in Premier, healthcare leaders can access cost reduction avenues, delivery system development and enhancement strategies, technology management, decision support tools, and a variety of opportunities for networking and knowledge transfer.

I very much appreciate this opportunity to share our views and recommendations on the need to expand participation in Medicare managed care options to include provider-sponsored organizations (PSOs). As the Medicare program faces its most serious crisis since its inception over 30 years ago, we are convinced that expanding beneficiary choice of private health plan options is an essential component of any strategy to preserve and strengthen the program for the 21st century.

Today's hearing brings into focus very significant advances that are occurring in the private sector to improve the quality and affordability of care through greater reliance on organized systems of care. As employers and other purchasers of health care services have put pressure on providers and insurers to limit premium increases and overall health care costs, new models for organizing and delivering care have emerged. We have seen the first generation of managed care plans—group and staff model HMOs—give way to HMOs with point-of-service options and preferred provider organizations (PPOs) promoting best clinical practices through utilization management. More recently, some employers have begun to contract directly with locally-based provider-sponsored organizations that are capable of providing a comprehensive array of health care services.

The purpose of this hearing is to learn more about how PSOs are serving patients in many communities and to consider how their advantages can be made available to the Medicare program and its beneficiaries. First, we do want to extend our appreciation to Congressman Greenwood of this Committee and to his colleagues on the Committee—Representatives Burr, Stearns, Stupak, and Whitfield—for introducing H.R. 475, a bill that would make qualified PSOs eligible as a Medicare coverage option. This measure carefully sets forth the terms and conditions for PSO participation in Medicare—holding them fully accountable while recognizing their unique structure.

What are PSOs?

Very simply, a PSO is an organized system of care serving patients in a local community. Typically, PSOs are sponsored by local hospitals, physicians and other licensed providers who are affiliated with each other through common ownership or control and share financial risk. These organizations are an attractive option to consumers who want to receive their health care from a network of local providers that have a long-term commitment to their communities. With their local base, PSOs are able to focus on improving health throughout their communities while coordinating care across the continuum of services required to diagnose and treat illnesses and injuries for its enrollees.

What really distinguishes PSOs from other forms of managed care is their provider base in contrast to an insurance plan or HMO where the insurer or plan is not directly involved in the provision of care. Insurers and HMOs generally must make arrangements with facilities and practitioners in order to deliver care to their enrolled members. In contrast, PSOs are both the plan and the direct provider of care. As such they can more easily put patients first and maintain a proper balance between the need to achieve efficiencies and the obligation to ensure the highest quality and consumer protection standards.

While not all PSOs are structured in exactly the same way, they all share some common features including: Integration of all clinical services supported by clinical and financial information systems and by adherence to community standards of practice; direct provision of a substantial portion of services by providers that share financial risk; and flexibility in the design of medical management approaches that are adapted to local needs and coordinated with other community resources.

We believe PSOs can offer a patient-focused delivery system that is equally attractive to beneficiaries in urban areas with considerable managed care competition as well as in rural areas where coordinated care systems have not often been available.

PSOs and Medicare

It is widely recognized that organized systems of care have been responsible for reducing the cost of private health coverage to employers and workers. In contrast to the fragmented, episodic fee-for-service system, coordinated care systems can also improve the quality and outcomes of care. The Medicare program has moved much more slowly than the private market in making managed care options available to beneficiaries. We believe there is now an opportunity, indeed a mandate, to begin taking advantage of these private sector successes by expanding beneficiary choices to include PSOs and other integrated care systems that meet appropriate standards.

Enrollment of Medicare beneficiaries in qualified HMOs has been growing dramatically recently—more than 25% per year—and the Congressional Budget Office in January predicted that the percentage of beneficiaries in risk-based HMOs would nearly double—from 11.7% to 22.9%—over the next 5 years. However, these figures

remain quite low in comparison with the private sector where fully two-thirds of workers with health coverage are in managed care plans.

One reason that Medicare lags behind the private sector with regard to managed care participation is that the program has limited private plan options to traditional HMOs and Competitive Medical Plans (CMPs.) We strongly supported provisions included in the Balanced Budget Act of 1995 that would have established federal standards and certification for PSOs in the Medicare program. However, in the final bill—which was vetoed—we believe the standards were too restrictive and that significant discretion was ceded to the states which would likely take very different approaches that could impede opportunities for PSOs and restrict beneficiary choices in some states.

Since that time, the Medicare program has launched a series of demonstrations designed to test the acceptability of a wider range of private plan options. As you may know, the Medicare Choices Demonstration involves 25 sites, 9 of which are PSOs. One of our owners, the Florida Hospital Healthcare System in Orlando, has already begun enrolling Medicare beneficiaries under a capitation-based risk contract with Medicare. Within its first two months of operation, the plan enrolled more than 4000 beneficiaries. Significantly, the plan was qualified directly by HCFA and was not required to obtain a state HMO license.

We are greatly encouraged by the strong interest that beneficiaries have displayed in the Orlando PSO. We know that many Premier hospitals and systems are capable of coordinating care for Medicare beneficiaries and are anxious to have this opportunity in their communities. Enactment of H.R. 475 would make PSOs more widely available and hold them accountable to appropriate financial, quality, and patient protection standards.

H.R. 475, The Medicare Provider-Sponsored Organization Act of 1997

The legislation introduced by Congressman Greenwood on January 21st, H.R. 475, includes a number of specific and important changes from the proposals that were offered during the Medicare debates in the last Congress. In our view, this legislation holds PSOs to even higher standards than are currently in place for HMOs that contract with Medicare. We think it is critically important to recognize that this measure is not an effort to lower Medicare standards or put beneficiaries at risk.

H.R. 475 sets forth the terms and conditions for PSO participation in the Medicare program. The measure builds on the requirements already in place under the current risk contractor program. A Medicare qualified PSO must have the capability to provide the full benefit package under a capitation payment including the *direct provision of substantially all* the covered benefits by providers who are under common control and share substantial financial risk. Financial solvency must be demonstrated by meeting a series of specific measures based on the current NAIC model HMO act. PSOs must also meet all current Medicare quality standards plus enhanced standards related to utilization review programs and physician participation in designing quality improvement programs.

We also believe that it's important to make sure that the enforcement and oversight of PSOs are carried out in an efficient and fair manner. Historically, state regulatory systems have not kept pace with the changing delivery system models in terms of the application of their licensure statutes. Thus, PSOs and other integrated delivery systems face in many states regulatory requirements designed for traditional health insurers or HMOs that must set aside reserves against claims and must contract with the providers that actually render services. As a result, H.R. 475 seeks to coordinate federal and state regulatory efforts by initially calling for federal certification of PSOs. After four years, state licensure would be required for PSOs in any state that adopted standards equivalent to the federal standards.

Finally, H.R. 475 includes a number of other provisions such as limited waivers of the enrollment composition rule (the so-called 50/50 rule), authorization for partial risk payment arrangements combining capitation with cost-based payments, uniform standards for the coverage of emergency services, and a limited preemption of state laws that prohibit the operation of managed care plans. These provisions help to ensure a level playing field for PSOs and a more consistent and appropriate set of standards through which they can be held accountable.

Conclusion

Mr. Chairman, we believe PSOs show great promise as an option for Medicare beneficiaries by giving them access to community-based, patient focused, coordinated care. This translates into real value for those who rely on Medicare for their health coverage. PSOs will expand the range of beneficiary choices, they will put clinical decisions back into the hands of local practicing physicians, they will meet

current consumer protection and quality assurance standards, and they will reduce the burden and frustration of the traditional fee-for-service claims system.

We believe that the enthusiasm with which Medicare beneficiaries have embraced the PSOs that are participating in the Medicare Choices demonstration is indicative of the reception they will receive if they become more widely available. It's important to remember that H.R. 475 represents a significant and much more comprehensive approach to establishing the conditions for and assuring the accountability of provider-sponsored organizations.

We urge this Committee to include this legislation in any Medicare reform legislation that may be recommended later this year. We look forward to working with you, Mr. Chairman, and the other members of the Committee in moving this bill forward.

Thank you for this opportunity to present our views and recommendations on this critical opportunity to expand Medicare choices.

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